Jurisdictional Statement

81-537

No.

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ALEXANDER L. STEVAS,
CLERK

In The

Supreme Court of the United States

October Term, 1981

BEECHWOOD SANITARIUM, A/K/A BEECHWOOD NURSING HOME,

Appellant,

v.

DAVID AXELROD, as Commissioner of Health of the State of New York; HOWARD F. MILLER, as Director of the Budget of the State of New York; and STATE HOSPITAL REVIEW AND PLANNING COUNCIL, a Council within the Department of Health of the State of New York,

Appellee.

On Appeal From The Appellate Division, Fourth Department, Of The Supreme Court Of The State Of New York

JURISDICTIONAL STATEMENT

September 11, 1981

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QUESTIONS PRESENTED

The New York State Plan for Medicaid reimbursement rate-setting, set forth in sections 2807 and 2808 of the New York Public Health law and 10 NYCRR Part 86-2, provides for two standards to be used in calculating Medicaid reimbursement to residential health care facilities. The standard used to calculate the capital costs of not-for-profit facilities permits recovery of depreciation costs and provides for reimbursement based upon generally accepted accounting principles. The standard used to calculate the capital costs of proprietary facilities denies reimbursement of depreciation, and requires calculation based upon unorthodox accounting methods. The questions presented are:

1. Whether the New York Medicaid reimbursement scheme is inconsistent with federal Medicaid provisions, found in 42 U.S.C. § 1396 et seq. and 42 C.F.R. Part 447, and therefore unconstitutional under the Supremacy Clause of Article VI of the United States Constitution, in that federal law prohibits variations in reimbursement formulae based upon differences in the forms of ownership of facilities, and requires that reasonable, accepted accounting and reimbursement standards be used for all Medicaid eligible facilities.

2. Whether the New York State Medicaid reimbursement scheme, which discriminates between reimbursement to proprietary residential health care facilities and reimbursement to not-for-profit facilities, violates the Equal Protection Clause of the

Fourteenth Amendment of the United States Constitution.

LIST OF PARTIES

All parties to this proceeding in the court below are named in the caption of this Jurisdictional Statement.

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REFERENCE TO REPORT OF OPINION BELOW

The opinion of the Appellate Division, Fourth Department, Supreme Court of the State of New York, from which this appeal is taken, is reported at 79 A.D. 2d 1084, and 435 N.Y.S.2d 819. The order of the Appellate Division denying reargument or leave to appeal, and the order of the Court of Appeals denying leave to appeal have not been reported.

JURISDICTION

This is a declaratory judgment action brought in New York State Supreme Court, Monroe County, after an exhaustion of administrative remedies, in which appellant contests the validity of New York State's Medicaid reimbursement scheme. This appeal, brought pursuant to 28 U.S.C. § 1257(2), is from an order

of the Appellate Division, Fourth Department, of the Supreme Court of the State of New York, entered on January 16, 1981, which affirmed the judgment of the New York State Supreme Court, Monroe County, granting appellees' motion for summary judgment and denying appellant's motion for summary judgment. On March 27, 1981, the Appellate Division denied appellant's motion for leave to appeal to the Court of Appeals, or in the alternative for reargument of the appeal in the Appellate Division. On June 16, 1981, the Court of Appeals of the State of New York denied appellant's motion for leave to appeal. This appeal is being docketed within 90 days from the denial of the motion for leave to appeal.

CONSTITUTIONAL PROVISIONS, STATUTES, REGULATIONS

Article VI, clause 2, United States Constitution:

". . . the Laws of the United States . . . shall be the Supreme Law of the Land. . . any thing in the Constitution or Laws of any State to the Contrary notwithstanding."

Fourteenth Amendment, section 1, United States Constitution:

". . . No State shall . . . deny to any person within its jurisdiction the equal protection of the laws."

The lengthy statutes, regulations and agency criteria which make up the federal and New York State Medicaid programs involved in this appeal are set forth verbatim in the Appendix to this statement. The following discussion summarizes the relevant law.

The Medicaid program, created by federal statute, 42 U.S.C. § 1396 et seq., as interpreted by federal regulations, 42 C.F.R. Part 447, is a block grant program in which the federal government acts in concert with participating states to provide medical assistance to the needy. Under Medicaid, the federal government sets basic standards for the provision of Medicaid assistance, and provides a portion of the Medicaid funds which ultimately aid Medicaid eligible individuals. States which choose to participate in the program provide additional funds and administer the program according to state developed plans which conform to mandatory federal guidelines. The portion of Medicaid funding borne by participating states varies from state to state. New York State provides fifty percent of the Medicaid funds paid to

qualified facilities under the New York program.

One element of the Medicaid program provides for reimbursement, with Medicaid funds, of certain costs incurred by skilled nursing facilities on behalf of Medicaid eligible patients. Federal law requires that such reimbursement be made on a "reasonably cost-related basis." 42 U.S.C. § 1396(a)(13)(E). The regulations governing the determination of allowable costs and payment methods are set forth at 42 C.F.R. Part 447. Specifically, the provisions at issue here mandate that:

1) reimbursement rates are to be set at a rate that reasonably takes into account actual allowable costs, 42 C.F.R. § 447.302;

2) reimbursement rates must be based upon uniform cost-finding methods applied to the allowable costs of all skilled nurs-

ing facilities, with no provision for any deviation from these methods to take into account facilities' form of ownership, 42 C.F.R. § 447.274, 447.276; and

3) itemized lists of allowable costs upon which states are to base the computation of reimbursement rates are to be prepared using generally accepted accounting principles. 42 C.F.R. § 447.274.

The Health Care Financing Administration (HCFA) of the United States Department of Health and Human Services has interpreted the federal Medicaid regulations in its recently issued draft of Standardized Review Criteria for Title XIX (Medicaid) Long-Term Care Payment Plans.[1/] The HCFA criteria relating to Medicaid regulations at issue in this case provide that:

1/ The full text of these criteria can be found in the Appendix to this statement.

A State has the prerogative to define allowable costs as it deems appropriate but such definitions must be reasonable. In determining the approvability of proposed definitions, consideration will be given as to whether the proposed definition (a) is reasonably cost-related and (b) is based on generally accepted accounting principles... In order for a State plan to be found reasonably cost related, it must address the following cost issues or items:

5. Capital costs must be defined and should include adequate descriptions of: (a) bases of depreciation (asset valuation), (b) methods of depreciation, (c) asset lives, (d) recapture of gains on sale, and (e) capital cost and capital cost limitations. ...

Generally speaking, the use of ownership (proprietary, non-proprietary, publicly-owned, etc.) as a grouping factor [for developing payment classifications] would not be acceptable because conditions of participation and services provided are defined in regulations and in no way are related to type of ownership or business organization. (emphasis in original.)

Federal regulations governing the Medicare program, which act as a gloss

upon the Medicaid regulations, provide that proprietary and not-for-profit facilities are to be treated equitably in setting reimbursement rates. 42 C.F.R. §405.402(b)(5). The Medicare regulations further provide that depreciation expense is an allowable capital cost reimbursable to all facilities, without any regard to the facilities' form of ownership. 42 C.F.R. § 405.402(c).

New York State has participated in the Medicaid program since 1966, and has promulgated statutory standards under which Medicaid reimbursement rates will be set. New York Public Health Law §§ 2807, 2808. The payment standards for residential health care facilities in force at all times relevant to this appeal have been set forth in section 2808 of the New York Public Health Law. In 1977 the New York State Legis-

lature amended section 2808 to authorize the State Commissioner of Health to promulgate Medicaid regulations relating reimbursement rates to real property costs. Under section 2808(2)(b), these regulations may provide for differentiation in capital cost reimbursement based upon facilities' forms of ownership. The New York Medicaid regulations do provide that, while depreciation is an allowable capital cost for voluntary and public facilities, 10 NYCRR § 86-2.19, depreciation is not an allowable capital cost for proprietory facilities. 10 NYCRR § 86-2.21.[2/] Further, the regu-

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2/ Appellees initially promulgated the discriminatory regulations as effective on January 1, 1976, although no statutory authority for them existed until the 1977 amendment of section 2808, which, itself, was not effective until January 1, 1978. This point, although not an issue here, was raised below and ignored by the courts.

lations provide an unorthodox accounting method to compute Medicaid reimbursement rates for the capital costs of proprietory facilities.

STATEMENT OF THE CASE

Appellant operates an eighty bed proprietary residential health care facility in Rochester, New York. This facility qualifies as a skilled nursing facility under the Medicaid program, and, therefore, receives Medicaid reimbursement for its costs, including capital costs incurred in providing care to Medicaid patients.

Appellees are responsible for establishing Medicaid reimbursement rates for all qualified facilities in New York based upon cost data supplied by the facilities. Appellant has supplied appellees with data relating to its

capital costs, including its depreciation expense. Appellees have calculated appellant's reimbursement rate without allowing costs for depreciation of its physical plant. This has resulted in reimbursement to appellant at a rate significantly lower than that which would be applied if depreciation was included in the capital cost component of its rate calculations. For example, according to appellees' own calculations, with respect to the years 1976 through 1979 appellant was denied $117,000 in depreciation cost reimbursement because it is proprietary.

Appellees have conceded (a) that appellant's Medicaid reimbursement was computed without consideration of its property depreciation, (b) that this reimbursement was computed based upon an accounting method which did not use generally accepted principles of cost

accounting, and (c) that the sole reason for this treatment was form of ownership, that is that appellant's facility is proprietary. If appellant's facility had been operated on a not-for-profit basis, depreciation would have been a factor in computing its reimbursement, and its reimbursement rate would then have been computed according to generally accepted accounting principles.

Maintaining that disparate treatment of proprietary and not-for-profit health care facilities is unfair and illegal, appellant brought its objections to the attention of the New York State Department of Health. Appellant was given no relief at the administrative level. Therefore, this action was instituted in state court in an attempt to have the New York Medicaid scheme for reimbursing long-term care facilities declared illegal.

While raising the challenge that the decision of the Department of Health was illegal under state law, appellant also presented and preserved its contentions that New York law, if construed to deny appellant's claim, would conflict with federal law and federal regulations. The first opportunity for judicial treatment of these issues was available when the parties each moved for summary judgment in New York State Supreme Court, Monroe County. Justice Robert E. White, issuing no opinion, granted summary judgment to appellees thereby denying all appellant's contentions under state and federal law.

Appellant then appealed to the Appellate Division, Fourth Department, of the New York State Supreme Court. In its briefs and oral argument, appellant presented its federal contentions. Affirming Justice White's order, the

Appellate Division issued a short memorandum opinion in which each claim made by the appellant was rejected in fairly summary fashion. The federal issues raised here were barely addressed. The Appellate Division found nothing in state or federal law which would require appellees to utilize generally accepted accounting principles in computing payments to facilities, although, as the HCFA criteria quoted above demonstrate, a state's plan for determining allowable costs cannot be deemed consistent with federal Medicaid law if it is not based upon generally accepted accounting principles.

This appeal is taken following unsuccessful motions to the Appellate Division for leave to appeal or reargument, and to the New York State Court of Appeals for leave to appeal.

THE QUESTIONS PRESENTED ON THIS APPEAL ARE SUBSTANTIAL

A. Whether New York State's Treatment of Proprietary Nursing Facilities Violates Federal Requirements Is An Important, Meritorious Issue.

Federal Medicaid law, summarized above, requires that states participating in the program reimburse qualified skilled nursing facilities uniformly, according to generally accepted accounting standards and on a reasonably cost-related basis. As interpreted and applied in this case, the New York State Medicaid program departs from these federal requirements in two ways. First, New York uses unorthodox accounting principles that depart significantly from generally accepted accounting standards and fail to provide reimbursement for depreciation expenses. Second, New York fails to treat proprietary and non-proprietary facilities uniformly,

thereby favoring one class of nursing facilities in a manner not permitted by the federal requirements.

This failure to treat the costs of all skilled nursing facilities uniformly, as federal law requires, 42 C.F.R. § 447.276, should, by itself, invalidate the New York program. In establishing and funding the Medicaid program, there was no federal intent to favor non-profit facilities. Thus, this appeal presents important, unresolved issues concerning state programs that discriminate against private enterprise, in violation of what appears to be a clear federal prohibition.

The federal Medicare regulations further support appellant's case. These regulations explicitly provide that all skilled nursing facilities are to be reimbursed equitably, regardless of their form of ownership, and that depre-

ciation costs are reimbursable. Judicial support exists for the proposition that the Medicare regulations act as a gloss upon Medicaid law. Minnesota Association of Health Care Facilities, Inc. v. Minnesota Department of Public Welfare, 602 F.2d 150, 154 (8th Cir. 1979).

New York's deliberate discrimination against proprietary facilities, and its failure to use generally accepted accounting standards, cannot be excused by reliance on a policy "to avoid abuse of the public purse and to facilitate overall reimbursement." Brief for Respondents on Appeal to Appellant Division at 25. Courts have held on several occasions that a state may not deviate from federal Medicaid guidelines to protect its public purse. Alabama Nursing Home Association v. Harris, 617 F.2d 388 (5th Cir. 1980); Catholic Medical Center

of Brooklyn and Queens, Inc., Division of St. Mary's Hospital v. Rockefeller, 305 F.Supp. 1256, 1268 (E.D.N.Y. 1969), aff'd 430 F.2d 1297 (2d Cir.), app. dismissed, 400 U.S. 931 (1970); Country Club Home, Inc. v. Harder, 228 Kan. 756, 620 P.2d 1140, modified, 228 Kan. 802, 623 P.2d 505 (1980); State ex rel. Montrie Nursing Home, Inc. v. Aggregy, 54 Ohio St.2d 394, 377 N.E.2d 497 (1978). While New York might properly be concerned about a form of fraud whereby nursing homes are sold to inflate their depreciation basis, it may remedy this evil only in such a manner that does not impose a penalty, contrary to federal law, on proprietary nursing facilities that have never engaged in such practices. Appellant's facility, for example, is of new construction and has never been sold. New York may not, without violating federal requirements,

disallow appellant's reasonable costs determined according to generally accepted accounting standards, when New York would allow such costs if this same facility had a different form of ownership. In any event, New York has imposed other regulatory controls which adequately prevent any potential abuse of depreciation figures by proprietary facilities seeking Medicaid reimbursement.3/

3/ These controls consist of requirements for the Commissioner's approval of construction costs for new facilities or the sale price upon transfer of ownership, 10 NYCRR § 86-2.21(a)(6), State Public Health Council approval of nursing home transfers, New York Public Health Law § 2801-a(4), 10 NYCRR § 701.3(b), (c), and regulations disallowing reimbursement for costs created by the sale of a facility, 10 NYCRR§ 86-2.17(k). These regulations are applicable to all residential health care facilities in New York State.

Appellant acknowledges that states have some flexibility in developing reimbursement methodologies. Where there are mandatory federal Medicaid guidelines, however, a state's flexibility is curtailed. Alabama Nursing Home Association v. Harris, 617 F.2d 388 (5th Cir. 1980). Thus, New York is not free to deviate from the federal requirement that generally accepted accounting principles be used as the basis for computing Medicaid reimbursement. See 42 C.F.R. § 447.374(c); HCFA Standardized Review Criteria for Title XIX. Nor may New York fail to apply uniform cost finding methods to all skilled nursing facilities, as mandated by federal regulations, 42 C.F.R. § 447.276(b).

In view of New York's failure to conform to federal requirements, appellant has more than a reasonable probability of success on this appeal.

Further, the issues raised here are substantial in nature.

Moreover, this appeal is of considerable significance to many organizations and individuals other than appellant, for a number of reasons. First, although New York may not have so intended, its failure to provide equitable reimbursement for proprietary facilities constitutes a serious inroad on the role of proprietary health care facilities in the delivery of health care services. The New York Medicaid system favors not-for-profit facilities and, thus, penalizes proprietary facilities. This penalty is imposed despite an apparent federal policy that opposes any "form of ownership" discrimination. Therefore, determination of whether New York has departed from a federal policy favoring, and indeed requiring, uniform and equitable treatment of proprietary

facilities may have a broad impact on the role of private enterprise in the health care field.

Second, the number of Medicaid eligible skilled nursing facilities that would be affected by a ruling by this Court in this case underscores the importance of this appeal. Nationwide, such facilities number in the thousands.[4/] As of December 31, 1977, New York State alone had 798 such facilities, with 383 of these being proprietary facilities.[5/] Therefore, at issue here is the availability of

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4/ See Nursing Home Survey of 1977, Summary for the United States (Series 13, #43, United States Department of Health and Human Services, Publication #PHS 79-1794, July 1979).

5/ Health Facilities Directory (New York State Department of Health 1978).

millions of Medicaid dollars to thousands of facilities providing residential health care to the needy.

Third, New York's failure to reimburse proprietary nursing facilities for their real property depreciation costs creates a serious shortfall in the facilities' capital available to repair and replace worn out equipment and buildings to meet Medicaid standards. This capital shortfall has a significant economic impact on the cost and availability of skilled nursing care to non-Medicaid eligible patients. Skilled nursing facilities receiving government funding through Medicaid rely on two sources of funds to meet their total costs: government funding and payment of fees by private patients. If Medicaid funding does not cover the costs of serving Medicaid patients, the facilities must choose between meeting their costs by increasing charges to private patients

on one hand, and losing money on the other. No federal policy would support either alternative. In fact, federal Medicare regulations which define the term "reasonable cost," a term used in the Medicaid context, make clear that private patients are not to bear any costs of participation in the program. 42 C.F.R. § 405.451(b)(1). As proprietary facilities are forced to lose money by accepting Medicaid patients, they are driven out of the business of providing health care to the needy. New proprietary facilities are not likely to be constructed unless reasonable costs, defined in accordance with accepted cost accounting principles to include recovery of depreciation costs, can be recovered consistently with profitable operation.

Fourth, this case presents this Court with an opportunity to define what Congress meant when it said that

Medicaid reimbursement should be made on a "reasonably cost-related basis." This elusive term has been confronted by federal and state courts. See, e.g., Alabama Nursing Home Association v. Harris, 617 F.2d 388 (5th Cir. 1980); Minnesota Association of Health Care Facilities, Inc. v. Minnesota Department of Public Welfare, 602 F.2d 150 (8th Cir. 1979); Country Club Home, Inc. v. Harder, 228 Kan. 756, 620 P.2d 1140, modified, 228 Kan. 802, 623 P.2d 505 (1980). This issue is squarely raised here by appellant's contention that New York's refusal to cover depreciation violates generally accepted accounting principles and fails to provide reimbursement on a "reasonably cost-related basis." The states administering Medicaid, as well as the courts, need guidance in construing this phrase that stands as the cornerstone of Medicaid

reimbursement to long-term care facilities.

Fifth, the issues presented here have not been resolved by any court other than the Appellate Division, Fourth Department, of the New York State Supreme Court. The New York court's opinion seems to be at odds with federal law, and does not give weight to the important federal policies of uniform treatment and fair cost reimbursement. The recent interpretation by HCFA of these requirements cannot be reconciled with New York's summary dismissal of these federal principles. Accordingly, the issues raised here should be addressed from a federal perspective, to ensure that states do not depart from federal requirements.

Finally, resolution of the issues presented here could have a broad impact on a number of social welfare programs.

This Court is respectfully called upon in this appeal to determine the degree to which a state administering a federally enacted program may deviate from federally mandated guidelines in the guise of protecting its fiscal integrity. As attempts to justify deviation from regulatory guidelines on grounds of economic hardship grow increasingly common, see American Textile Manufacturers Institute, Inc. v. Donovan, 49 U.S.L.W. 4720 (June 17, 1981), the issues raised here grow ever more crucial.

B. Whether New York's Discriminatory Treatment of Proprietary Facilities Violates The Fourteenth Amendment Raises A Substantial Issue.

The parties to this appeal agree that New York State's Medicaid scheme treats proprietary facilities and not-for-profit facilities in a disparate

manner. This disparate treatment amounts to discrimination in violation of the Fourteenth Amendment's Equal Protection Clause.

Under the Fourteenth Amendment, a state scheme of regulation which discriminates between two classes of regulated entities must fall, if no rational basis for the discrimination exists. City of New Orleans v. Dukes, 427 U.S. 297 (1976). As indicated above, the only basis offered by appellees for the discrimination here is "to avoid abuse of the public purse and to facilitate overall reimbursement." The protection of the public purse has repeatedly been rejected as a reasonable basis for state-imposed limitations on Medicaid reimbursement. Even assuming that New York's explanation of its discrimination against proprietary facilities states a valid goal, a rational nexus between

this goal and the discrimination at issue is totally lacking.

It makes no sense to deny depreciation reimbursement to all proprietary skilled nursing facilities as a method to ensure that some facilities do not recover more Medicaid reimbursement than they deserve. New York's concern is apparently with a limited practice of repeated sales of such facilities to inflate their stated basis for depreciation, yet the regulatory remedy fails to address this evil in a rational manner. The New York State Medicaid program already contains adequate regulatory controls on such potential abuse.[6/] The state's decision to impose the discriminatory system at issue here despite adequate controls to prevent potential

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6/ See n. 3, supra.

abuse, is nothing more than action taken to benefit not-for-profit nursing facilities at the expense of private enterprise. This action contravenes federal public policy, and, lacking a rational basis, violates the Fourteenth Amendment.

CONCLUSION

For these reasons, this Court should note probable jurisdiction of this appeal.

Respectfully submitted,

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81-537

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ALEXANDER L. STEVAS,

In The

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OCTOBER TERM, 1981

No.

BEECHWOOD SANITARIUM, A/K/A BEECHWOOD NURSING HOME,

Appellant,

— v. —

DAVID AXELROD, As Commissioner of Health of the State of New York; HOWARD F. MILLER, As Director of the Budget of the State of New York; and STATE HOSPITAL REVIEW AND PLANNING COUNCIL, A Council within the Department of Health of the State of New York,

Appellee.

On Appeal From The Appellate Division, Fourth Department, of the Supreme Court of the State of New York

APPENDIX TO JURISDICTIONAL STATEMENT

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September 11, 1981

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STATE OF NEW YORK SUPREME COURT
APPELLATE DIVISION FOURTH DEPARTMENT

BEECHWOOD SANITARIUM, Also Known as
BEECHWOOD NURSING HOME,

Appellant,

v.

DAVID AXELROD, M.D., as Commissioner
of Health of the State of New York,
et al.,

Respondents.

Decided: January 16, 1981

PRESENT: HON. RICHARD J. CARDAMONE, Presiding
Justice

HON. RICHARD D. SIMONS,
HON. STEWART F. HANCOCK, JR.
HON. JOHN H. DOERR
HON. EMMETT J. SCHNEPP,
Associate
Judges

OPINION

Order unanimously affirmed, without costs. Memorandum: Plaintiff, a proprietary nursing home facility and a qualified provider under Medicare and Medicaid programs, seeks declaratory relief challenging defendants' calculation of rates to which it claims entitlement for delivery of health care services to eligible recipients under the Medicaid program (Social Security Act, tit 19; US Code, tit 42, §1936 et seq.). Plaintiff also disputes the accounting methodology employed by defendants in arriving at the applicable rates. Whether the action is properly one to be determined by way of an action for declaratory judgment or through an article 78 proceeding, all parties agree that plaintiff's action is limited to a four-month period from defendants' rejection of its administrative appeals on June 7, 1979. This would require the action to be commenced by October 7, 1979 which was a Sunday followed by Columbus Day (Oct. 8,

1979), a public holiday. Service of the summons and complaint on October 9, 1979 commencing this action was, therefore, timely (see General Construction Law, §30). Plaintiff argues that in computing the rate to which it claims it was statutorily entitled defendant commissioner acted capriciously and arbitrarily, erred in excluding depreciation expenses from the formula and failed to use generally accepted accounting principles in arriving at the formula. While it is true that providers of health care services are required to utilize generally accepted accounting principles in submitting financial and statistical report data to the State (10 NYCRR 86-2.4), no similar requirement is exacted from defendants by either State or Federal guidelines. Medicare regulations, for instance, provide that an appropriate allowance for depreciation is an allowable cost (42 CFR 405.402[b][5]; 42 CFR 405.415[a]). However, in interpreting Medicaid guidelines it has been recognized that "the legislative history leaves no doubt that Congress intended

states to have the option to adopt the Medicare principles and standards, but not to require that states adopt these principles and standards" (41 Fed Reg 27302). This flexibility was recently recognized in Alabama Nursing Home Assoc. v. Harris (617 F2d 388, 392) wherein the court stated: "Congress intended that state authorities in developing methodologies for reasonable cost related reimbursement have great flexibility in the areas of cost-finding and rate-setting. The legislative history indicates that states are to be free to experiment with methods and standards for payment that would be simpler and less expensive than the complex Medicare reasonable cost formula." Subdivision 3 of section 2807 of the Public Health Law sets forth certain guidelines for Medicaid reimbursement and mandates that prior to the approval of rates the commissioner is to consider, inter alia, the elements of cost. In making reimbursement he need only do so at a rate reasonably related to the costs of the services performed, not at a rate reflecting

actual costs (Matter of Broadacres Skilled Nursing Facility v. Ingraham, 51 AD2d 243). Plaintiff of course is entitled to reasonable compensation for the costs of patient care in its facility. However, so long as the formula by which it is reimbursed has a rational basis and is reasonably related to cost, plaintiff has no cause to complain. The statutes and regulations under which providers of health care services are reimbursed and the methodology employed by defendants in carrying out the legislative mandate meet this test of rationality. In this highly regulated, much investigated area of nursing home care, plaintiff has a heavy burden of showing that the formulas employed by defendants were arbitrary or capricious and invaded its constitutional perogatives. It has failed to meet this burden and the grant of summary judgment in favor of defendants was proper. (Appeal from order of Monroe Supreme Court - summary judgment).

STATE OF NEW YORK
COURT OF APPEALS

Motion Number 549

BEECHWOOD SANITARIUM a/k/a
BEECHWOOD NURSING HOME,

Appellant,

-vs-

DAVID AXELROD, M.D. as
Commissioner of Health of the
State of New York, et al.,

Respondents.

Motion for leave to appeal denied with twenty dollars costs and necessary reproduction disbursements.

Date of Decision: June 16, 1981

STATE OF NEW YORK SUPREME COURT
APPELLATE DIVISION FOURTH DEPARTMENT

BEECHWOOD SANITARIUM, a/k/a
BEECHWOOD NURSING HOME,

Appellant,

v. ORDER

DAVID AXELROD, M.D., as Commissioner
of Health of the State of New York,
Howard F. Miller, as Director of the
Budget of the State of New York,
et ano,

Respondents.

Entered: March 27, 1981

PRESENT: HON. RICHARD J. CARDAMONE, Presiding
Justice

HON. RICHARD D. SIMONS,
HON. STEWART F. HANCOCK, JR.,
HON. JOHN H. DOERR,
HON. EMMETT J. SCHNEPP,

Associate
Judges

The above named Beechwood Sanitarium, a/k/a Beechwood Nursing Home having duly moved before this Court for an order granting reargument of the appeal herein or, in the alternative, for leave to appeal to the Court of Appeals from the order of this Court, entered January 16, 1981,

Now, after reading and filing the affidavit of Michael R. Wolford sworn to February 25, 1981, the notice of said motion, together with proof of due service thereof upon counsel for the opposing party, the opposing affidavit of Joseph F. Gibbons sworn to March 3, 1981 and due deliberation having been had thereon,

It is hereby ORDERED, that said motion be and the same hereby is denied.

At a Special Term of Supreme Court, Monroe County, held at Rochester, New York, on March 18, 1980.

PRESENT: HONORABLE ROBERT E. WHITE
Justice Presiding

STATE OF NEW YORK
SUPREME COURT COUNTY OF MONROE

BEECHWOOD SANITARIUM a/k/a BEECHWOOD NURSING HOME,

Plaintiff,

vs

ORDER

DAVID AXELROD, M.D., Commissioner of Health of the State of New York, and HOWARD F. MILLER, Director of the Budget of the State of New York,

INDEX NUMBER 867/80

STATE HOSPITAL REVIEW AND PLANNING COUNCIL, a Council within the Department of Health of the State of New York,

Defendants.

The plaintiff, Beechwood Sanitarium a/k/a Beechwood Nursing Home, by its attorneys Nixon, Hargrave, Devans and Doyle having moved for an order granting to it summary judgment on its complaint and the defendants by their

attorneys, Robert Abrams, Attorney General of the State of New York, having cross-moved for an order granting to them summary judgment dismissing plaintiff's complaint and the said motions having regularly come on to be heard on March 18, 1980,

NOW upon reading and filing the Notice of Motion dated January 23, 1980, and the affidavits of Herbert Chambery and Letty Gail Schacht in support of said motion, and upon the affidavit of William S. Gormley dated February 27, 1980 in opposition thereto and in support of the cross-motion and after hearing Michael R. Wolford, Esq. of counsel for the plaintiff in support of said motion and after hearing Philip S. Glickman, Esq., and Eugene Laks, Esq., of counsel for the defendants in opposition thereto and in support of their cross-motion and after due deliberation having been held thereon,

NOW, upon motion of Robert Abrams, Attorney General of the State of New York,

attorney for defendants it is

ORDERED that plaintiff's motion for summary judgment be denied, and defendants' cross-motion for summary judgment be granted dismissing the complaint of the plaintiff.

Dated: April 22, 1980

S/ ROBERT E. WHITE
Robert E. White
J.S.C.

ENTERED: May 16, 1980
Monroe County
Clerk's Office

STATE OF NEW YORK
DEPARTMENT OF HEALTH

OFFICE OF HEALTH SYSTEMS
MANAGEMENT

DAVID AXELROD, M.D.
Commissioner

ALBANY, N.Y.

June 6, 1979

Mr. Brook Chambery
Beechwood Nursing Home
900 Culver Road
Rochester, New York 14609

Re: Appeal # H807265 (underlying numbers 719611); Appeal # H 813753 (underlying numbers 702420, and 703828); and Appeal # H 905161 (underlying number 802305)

Dear Mr. Chambery:

The above appeals have been reviewed as follows:

With respect to the items contained in your letter of March 3, 1978, Appeal # H 807265 refers first to incorrect project costs. This was corrected on Appeal # 903751.

Secondly, as to project costs being retroactive, this questioned the methodology used by Office of Health Systems Management and

therefore is an issue of law and an administrative hearing is not available under Section 86-2.14(b)(2).

The third item which deals with depreciation taken to compute fair rental has been corrected on audit.

The last item referred to in your March 3, 1978 letter, unamortized building costs, is being revised as requested.

In regard to those items set forth in your letter of April 14, 1978:

Appeal # H 813753 refers first to use of incorrect approved project costs. Office of Health Systems Management acknowledges your contention. However, in view of the fact that an audit currently in process may have further adjustments on this issue, a hearing after audit, pursuant to regulations, would be the more appropriate forum.

Secondly, with respect to the depreciable

life of the building, a question of fact is indicated as required under 86-2.14(b)(2) and a notice of hearing will be issued.

The third item which dealt with family salaries has been granted as requested.

The fourth item in the April 14, 1978 letter, which deals with the return on equity is a challenge to the administrative determination of the methodology to be used in apportioning equity, which is a legal issue and not entitled to a hearing under 86-2.14(b)(2).

Those items set forth in your letter of December 5, 1978, with respect to appeal # H905161 are:

First and second, as to administrator's and medical director's ceilings, a factual issue exists under 86-2.14(b)(2) and it will be included in the notice of hearing.

Thirdly, the question of family salaries has been granted as requested and will be

included with the revised rates computed by the Bureau of Audit Appeals.

The fourth item in this letter deals with non-allowable expenses. I am informed that a recent audit disclosed what some of the expenses were for and these were added back. For those items not added upon audit, it is my understanding that an audit hearing pursuant to regulation, will be afforded you on this issue.

The fifth item refers back to the item of appeal as originally stated in your letter of January 9, 1978, item # 6, to wit: depreciation of equity in movable equipment, I am informed, is addressed in the audit in your favor; hence, this aspect will be adjusted administratively through the audited rates.

With regard to the sixth item, your appeal of building depreciation expense is a challenge to the particular methodology relied upon, by Office of Health Systems

Management, and is a legal issue and hence not entitled to an administrative hearing under 86-2.14(b)(2).

The seventh question which questions the reimbursement for mortgage costs is another challenge to the methodology used by Office of Health Systems Management and is a legal issue, not entitled to an administrative hearing under 86-2.14(b)(2).

The eighth item, on return on equity in rate year 1978, concerns the methodology used in reimbursement rate setting, pursuant to 86-2.21 and 86-2.28. This is a legal issue, hence not entitled to an administrative hearing under 86-2.14(b)(2).

The ninth point with regard to the minimum wage adjustment being added to the trend factor for rate calculation would depend on the facility's response to the Health Facilities Memorandum #78-14 dated March 9, 1978. Please submit the information request-

ed in Memorandum # 78-14 within thirty days from the date of this letter. If possible the matter will be taken care of administratively upon receipt of the information.

In regard to the last item on this appeal concerning the trend factor adjustment, it appears that this is a challenge to the methodology used by Office of Health Systems Management in reimbursement rate setting and as such raises a question of law, not of fact as required for a hearing. Therefore, you are not entitled to an administrative hearing pursuant to 86-2.14(b)(2) on this issue.

In summary the following items will be included in a forthcoming notice of rate hearing: the question of the depreciable life of the building; administrators and medical directors ceiling.

The following will be included in an audit hearing pursuant to 10 NYCRR 86-2.7(f): approved project costs and non-allowable

expenses.

Very truly yours,

Francis P. Mulderry

Rate Review Officer

STATE OF NEW YORK
SUPREME COURT

APPELLATE DIVISION
FOURTH DEPARTMENT

BEECHWOOD SANITARIUM, a/k/a BEECHWOOD NURSING HOME,

Plaintiff-Appellant,

-vs-

DAVID AXELROD, M.D., as Commissioner of Health of the State of New York; HOWARD F. MILLER, as Director of the Budget of the State of New York; STATE HOSPITAL REVIEW AND PLANNING COUNCIL, a Council within the Department of Health of the State of New York,

Defendants-Respondents.

NOTICE OF APPEAL TO THE SUPREME COURT OF THE UNITED STATES

Notice is hereby given that the plaintiff-appellant, Beechwood Sanitarium, a/k/a Beechwood Nursing Home, appeals to the Supreme Court of the United States from the final order of the Appellate Division, Fourth Department of the Supreme Court of the State of New York, affirming summary judgment in favor of the defendants-respondents, entered on January 16, 1981. The New York State Court of Appeals denied the plaintiff-appellant's motion for leave to appeal on June

16, 1981.

This appeal is taken pursuant to 28 U.S.C. §1257(2).

Dated: Rochester, New York
September 2, 1981

NIXON, HARGRAVE, DEVANS & DOYLE
Attorneys for Plaintiff-Appellant
Lincoln First Tower
Rochester, New York 14603
716-546-8000

TO: ROBERT ABRAMS
Attorney General of the State of New York
Attorney for Defendants-Respondents
The Capitol
Albany, New York 12224
518-474-7162

The foregoing Notice of Appeal was served upon Robert Abrams, Attorney General of the State of New York, attorney for appellees, on September 8, 1981. This Notice was filed with the Appellate Division, Fourth Department, Supreme Court of the State of New York, on September 8, 1981, and with the New York State Supreme Court, Monroe County on September 9, 1981. This Notice was mailed to the

New York State Court of Appeals for filing on September 9, 1981.

42 U.S.C. §1396a(a)(13)(E)

a) a state plan for medical assistance must (13) provide _____

* * *

(E) effective July 1, 1976, for payment of the skilled nursing facility and intermediate care facility services provided under the plan on a reasonable cost related basis, as determined in accordance with methods and standards which shall be developed by the State on the basis of cost-finding methods approved and verified by the Secretary.

* * *

TITLE 42 CODE OF FEDERAL REGULATIONS

§405.402 Cost reimbursement; general.

(a) In formulating methods for making fair and equitable reimbursement for services rendered beneficiaries of the program, payment is to be made on the basis of current costs of the individual provider, rather than costs of a past period or a fixed negotiated rate. All necessary and proper expenses of an institution in the production of services, including normal standby costs, are recognized. Furthermore, the share of the total institutional cost that is borne by the program is related to the care furnished beneficiaries so that no part of their cost would need to be borne by other patients. Conversely, costs attributable to other patients of the institution are not to be borne by the program. Thus, the application of this approach, with appropriate accounting support, will result in meeting actual costs of services to beneficiaries as such costs vary from institution to institution. However, payments to providers of services

for services rendered health insurance program beneficiaries are subject to the provisions of §§405.455 and 405.460.

(b) Putting these several points together, certain tests have been evolved for the principles of reimbursement and certain goals have been established that they should be designed to accomplish. In general terms, these are the tests or objectives:

(1) That the methods of reimbursement should result in current payment so that institutions will not be disadvantaged, as they sometimes are under other arrangements, by having to put up money for the purchase of goods and services well before they receive reimbursement.

(2) That, in addition to current payment, there should be retroactive adjustment so that increases in costs are taken fully into account as they actually occurred, not just prospectively.

(3) That there be a division of the allowable costs between the beneficiaries of this program and the other patients of the provider that takes account of the actual use of services by the beneficiaries of this program and that is fair to each provider individually.

(4) That there be sufficient flexibility in the methods of reimbursement to be used, particularly at the beginning of the program, to take account of the great differences in the present state of development of record-keeping.

(5) That the principles should result in the equitable treatment of both nonprofit organizations and profitmaking organizations.

(6) That there should be a recognition of the need of hospitals and other providers to keep pace with growing needs and to make improvements.

(c) As formulated herein, the principles give recognition to such factors as de-

preciation, interest, bad debts, educational costs, compensation of owners, and an allowance for a reasonable return on equity capital of proprietary facilities. However, costs such as depreciation, interest on borrowed funds, a return on equity capital (in the case of proprietary providers), and other costs related to certain capital expenditures are subject to the provisions of §405.435, "Nonallowable costs related to certain capital expenditures." With respect to allowable costs some items of inclusion and exclusion are:

(1) An appropriate part of the net cost of approved educational activities will be included.

(2) Costs incurred for research purposes, over and above usual patient care, will not be included.

(3) Grants, gifts, and income from endowments will not be deducted from operating costs unless they are designated by the donor

for the payment of specific operating costs.

(4) The value of services provided by nonpaid workers, as members of an organization (including services of members of religious orders) having an agreement with the provider to furnish such services, is includable in the amount that would be paid others for similar work.

(5) Discounts and allowances received on the purchase of goods or services are reductions of the cost to which they relate.

(6) Bad debts growing out of the failure of a beneficiary to pay the deductible, or the coinsurance, will be reimbursed (after bona fide efforts at collection).

(7) Charity and courtesy allowances are not includable, although "fringe benefit" allowances for employees under a formal plan will be includable as part of their compensation.

(8) A reasonable allowance of compensa-

tion for the services of owners in profit-making organizations will be allowed providing their services are actually performed in a necessary function.

(9) Reasonable cost of physicians' direct medical and surgical services (including supervision of interns and residents in the care of individual patients) rendered in a teaching hospital may be reimbursed as a provider cost (see § 405.465) where elected as provided for in § 405.521 of this part.

(d) In developing these principles of reimbursement for the health insurance program, all of the considerations inherent in allowances for depreciation were studied. The principles, as presented, provide options to meet varied situations. Depreciation will essentially be on a historical cost basis but since many institutions do not have adequate records of old assets, the principles provide an optional allowance in lieu of such depreciation for assets acquired before 1966. For assets acquired after 1965, the historical cost basis

must be used. All assets actually in use for production of services for title XVIII beneficiaries will be recognized even though they may have been fully or partially depreciated for other purposes. Assets financed with public funds may be depreciated. Although funding of depreciation is not required, there is an incentive for it since income from funded depreciation is not considered as an offset which must be taken to reduce the interest expense that is allowable as a program cost.

(e) [Reserved]

(f) A return on the equity capital of proprietary facilities is an allowable cost in profit-making organizations. The rate of return may not exceed one and one-half times the average long-term rate of interest on obligations issued for purchase by the Federal Hospital Insurance Trust Fund.

(g) The Health Care Financing Administration is authorized to issue temporary instructions modifying the provisiors of this subpart to the extent it finds appropriate for cost re-

porting periods ending after June 30, 1973, in order to implement sections 201 (Coverage for Disability Beneficiaries Under Medicare) and 299I (Chronic Renal Disease Considered to Constitute Disability) of Pub. L. 92-603. In so doing, rules may be developed for establishing limits on costs and services above which reimbursement shall be made only upon appropriate justification. For special rules concerning health maintenance organizations (HMO's) and providers of services and other health care facilities that are owned or operated by an HMO, or related to an HMO by common ownership or control, see §§ 405.2042(b)(14) and 405.2050(c).

§ 405.435 Nonallowable costs related to certain capital expenditures

(a) Principle. Effective with respect to any capital expenditure, as defined in 42 CFR Part 100, the obligation for which is incurred after December 31, 1972, or after the effective date of an agreement executed between a State and the Secretary pursuant to section 1122 of the Act, whichever date is later, the depreciation, interest on borrowed funds, return on equity capital (in the case of proprietary providers), and any other costs attributable to such capital expenditure, where the Secretary has determined that such proposed capital expenditure has not been submitted to the designated planning agency as required, or that it has been determined by such agency to be inconsistent with the standards, plans, or criteria developed to meet the need for adequate health care facilities (as defined in 42 CFR 100.101-110) are not allowable. Other costs related to such

capital expenditures include title fees; permit and license fees; broker commissions; architect, legal, accounting, and appraisal fees; interest, finance, or carrying charges on bonds, or notes; and other costs incurred for borrowing funds. The reasonable costs incurred by a provider for studies, surveys, designs, plans, working drawings, specifications, and other activities essential to the acquisitions, improvement, expansion, or replacement of the plant and equipment which are conducted to enable the provider to properly determine whether the proposed capital expenditure would be in compliance with the standards, plans, or criteria developed by the designated planning agency are allowable, except if the provider makes the capital expenditure and does not receive the required approval.

(b) Applicability. Under the principle specified in paragraph (a) of this section, any costs related to capital expenditures, the obligation for which was incurred by or on behalf

of a provider subsequent to 1972 (except as described in paragraph (c) of this section), are not allowable where the Secretary has determined that the capital expenditures have not been submitted to the designated planning agency as required or that they have been determined to be inconsistent with the standards, plans, or criteria developed by the designated planning agency or other health planning agency in the State to meet the need for adequate health care facilities in the area covered by the plan or plans so developed (see 42 CFR 100.101-100.110). Costs claimed by a provider in connection with capital assets which are donated or transferred to a provider are also subject to the application of such principle. Such principle also applies to the reasonable equivalent of that portion of any rental expense incurred pursuant to a lease or a comparable arrangement (and to any amounts deposited under the terms of such a lease or comparable arrangement in computing the return on equity capital)

that would have been excluded had the provider acquired such a facility or equipment by purchase. The amounts excluded are not subject to reimbursement under any other provisions of Title XVIII of the Act.

(c) Exceptions. The limitation on recognition of costs attributable to capital expenditures discussed in this section does not apply to:

(1) A provider furnishing health care services as of December 18, 1970, which on such date was committed to a formal plan of expansion or replacement, with respect to such expenditures as may be made or such obligations as may be incurred for capital items included in such plan where preliminary expenditures toward the plan of expansion or replacement (including payments for studies, surveys, designs, plans, working drawings, specifications, and site acquisition, essential to the acquisition, improvement, expansion, or replacement of the health care facility or equipment concerned) of $100,000 or more, had been made

during the 3-year period ending December 17, 1970, or,

(2) Christian Science sanatoriums operated, or listed and certified, by the First Church of Christ, Scientist, Boston, Massachusetts, or

(3) Capital expenditures the obligations for which were incurred by or on behalf of a provider prior to 1973, or

(4) Capital expenditures the exclusion of which the Secretary has determined would:

(i) Discourage the operation or expansion of a provider which has demonstrated its capability of providing comprehensive health care services efficiently, effectively, and economically; or

(ii) Otherwise be inconsistent with the effective organization and delivery of health services or the effective administration of Title V, XVIII, or XIX of the Act.

(d) Appeals. See § 405.1890 for appeal rights of a provider or other person dissatisfied with a determination under section 1122 of the Act (42 U.S.C. 1320a-1).

§ 447.272 Definitions.

For the purposes of §§ 450.271-450.316 -

"Accrual method of accounting" means that revenue is reported in the period when it is earned, regardless of when it is collected, and expenses are reported in the period in which they are incurred, regardless of when they are paid.

"Bad debts" are amounts considered to be uncollectable from accounts and notes receivable for services provided.

"Cash method of accounting" means that revenues are recognized only when cash is received, and expenditures for expense and asset items are not recorded until cash is disbursed for them.

"Charity allowances" are reductions in the provider's charges because of the patient's indigence or medical indigence.

"Cost finding" means the process of recasting the data derived from the accounts ordinarily kept by a provider to determine costs of each type of service by allocating direct costs and prorating indirect costs.

"Courtesy allowances" are a reduction in the provider's charges in the form of an allowance to physicians, clergy, and others. Employee fringe benefits, such as hospitalization and personnel health programs, not are [sic] courtesy allowances.

"Generally accepted accounting principles" means accounting principles approved by the American Institute of Certified Public Accountants.

"Generally accepted auditing standards" means auditing standards approved by the American Institute of Certified Public Accountants.

"Long-term care facility services" means skilled nursing care facility services and intermediate care facility services.

"Provider" means a provider of skilled nursing facility or intermediate care facility services.

"Retrospective payment system" means a system in which payment is made on the basis of a provisional payment rate set prospectively

for an accounting period, and in which payments may be retrospectively adjusted on the basis of the cost experience during the accounting period.

§ 447.273 Reasonable cost-related basis for long-term care facility services.

The Medicaid agency must pay for long-term care facility services on a reasonable cost-related basis in accordance with §§ 447.274 through 447.311.

Cost Finding and Reporting

§ 447.274 Provider cost reports.

(a) No later than 3 months after the close of the cost reporting year, each provider must submit a cost report to the Medicaid agency.

(b) The cost report must include -

(1) An itemized list of the provider's allowable costs under §§ 447.278-447.284 for the cost reporting year or for the period of participation in the plan if less than a full year; and

(2) A list of the costs of the various

services provided under the plan, as determined by applying the agency's approved cost-finding method to the provider's allowable costs.

(c) The itemized list of allowable costs must be complied on the basis of generally accepted accounting principles and the accrual method of accounting. The cash method of accounting is acceptable for public institutions.

(d) There must be a uniform cost report form for all skilled nursing facilities (SNF's) and a uniform cost report form for all intermediate care facilities (ICF's). However, the same form may be used by both SNF's and ICF's.

§ 447.275 Dates of cost reporting year.

(a) The State plan must specify the inclusive dates of the cost reporting year. The year need not be the same for all providers.

(b) The plan must specify the beginning date of the first cost reporting year, which must be no later than January 1, 1977.

§ 447.276 Cost-finding method.

(a) The plan must specify the cost-finding method or methods to be used by providers.

(b) There must be a uniform method for all SNF's and a uniform method for all ICF's. The same method may be used by both.

(c) The cost-finding method must be approved by the Regional Medicaid Director. Medicare cost-finding methods specified under § 405.453(d) of this chapter will be approved automatically. The Regional Medicaid Director may approve other cost-finding methods.

§ 447.277 Recordkeeping.

(a) Each provider must keep its financial and statistical records for the cost reporting year for at least 3 years after the date of submission of the cost report form to the Medicaid agency.

(b) The records must be accurate and in sufficient detail to substantiate the costs reported under § 447.274.

(c) Each provider must make the records

available on request to representatives of the agency or HHS.

§ 447.278 Items of expense included in allowable cost: General provisions.

The plan must specify the items of expense that are allowable costs.

§ 447.279 Cost of meeting certification standards.

Allowable costs for SNF's and ICF's include all items of expense providers must incur -

(a) To meet the definition of SNF services or ICF services in § 440.40(a) or § 440.150 of this subchapter;

(b) To comply with the standards for SNF's or ICF's in Part 442 of this subchapter;

(c) To comply with requirements established by the State agency responsible for establishing and maintaining health standards under §431.610 of this subchapter; and

(d) To comply with any other requirements for licensing under State law that must be met to provide SNF or ICF services.

§ 447.281 Costs of routine services.

(a) Allowable costs include all items of expense that providers incur in providing routine services.

(b) "Routine services" means regular room, dietary and nursing services; minor medical and surgical supplies; and the use of equipment and facilities.

(c) The following are examples of expenses that allowable costs for routine services must include:

(1) All general nursing services, including but not limited to administration of oxygen and related medications, handfeeding, incontinency care, tray service, and enemas.

(2) Items furnished routinely and relatively uniformly to all patients, such as patient gowns, water pitchers, basins, and bedpans.

(3) Items stocked at nursing stations or on the floor in gross supply and distributed or used individually in small quantities such as alcohol, applicators, cotton balls, bandaids,

antacids, aspirin (and other nonlegend drugs ordinarily kept on hand), suppositories, and tongue depressors.

(4) Items used by individual patients but which are reusable and expected to be available, such as ice bags, bedrails, canes, crutches, walkers, wheelchairs, traction equipment, and other durable medical equipment;

(5) Special dietary supplements used for tube feeding or oral feeding, such as elemental high nitrogen diet, even if written as a prescription item by a physician (because these supplements have been classified by the Food and Drug Administration as a food rather than a drug);

(6) Laundry services other than for personal clothing.

§ 447.282 Bad debts.

Allowable costs include only bad debts that are attributed to cost sharing amounts as defined in §§ 447.50-447.59.

§ 447.283 Items of expenses not included in allowable costs.

Allowable costs do not include charity and courtesy allowances.

§ 447.284 Purchases from related organizations: Limit on costs.

(a) Costs of services, facilities, and supplies furnished by organizations related to the provider by common ownership or control must not exceed the lower of the cost to the organization or the price of comparable services, facilities, or supplies purchased elsewhere.

(b) The cost report must identify related organizations and costs.

Audits

§ 447.290 Audit procedures.

The plan must describe the State's procedures for audits.

§ 447.291 Cost report desk analysis.

The agency must analyze each cost report within 6 months of its receipt to verify, to the extent possible, that the provider has complied with

§ 447.274.

§ 447.292 Onsite audits and exemption.

(a) The agency must provide for an onsite audit of the financial and statistical records of at least one-third of the providers each year of a 3-year period that begins at the close of the first cost reporting year (see § 447.275). All providers must be audited within the 3-year period.

(b) The Regional Medicaid Director may exempt a State from paragraph (a) of this section if -

(1) The State has a continuing audit program;

(2) The agency has completed onsite audits of the financial and statistical records of all providers during the 3-year period preceding the end of the first cost reporting period; and

(3) Each onsite audit was conducted in accordance with generally accepted auditing standards and was sufficiently comprehensive in scope to determine -

(i) That only proper items of cost applicable to Medicaid services were in the provider's calculation of its costs; and

(ii) Whether expenses attributable to the items of cost were accurately determined and reasonable.

§ 447.293 Continuing audits.

(a) Each year the agency must provide for onsite audit of the financial and statistical records of at least 15 percent of participating facilities selected as follows:

(1) At least 5 percent of participating facilities selected at random.

(2) At least 10 percent of participating facilities selected by profiles of costs or other factors established by the agency.

(b) These yearly audits must begin in the fourth year after the first cost reporting year. However, for a State exempted from on-site audits under § 447.292, these audits must begin in the year after the first cost reporting year.

§ 447.294 Audit standards.

(a) Audits must meet generally accepted auditing standards. The adoption of the audit standards in Health Insurance Manual (HIM-18), issued under the Medicare program, is recommended, but the agency may establish its own standards.

(b) Audits of providers' cost reports, financial records, and other pertinent documents must be adequate to verify - -

(1) That the provider has included only those expense items that the agency has specified as allowable costs under § 450.278 in compiling the costs of services;

(2) That the provider has accurately determined allowable costs under § 447.274(b)(1);

(3) That the provider has accurately attributed allowable costs to cost of services under § 447.274(b)(2); and

(4) That the provider's allowable costs are reasonable.

§ 447.294 Audit standards.

(b) Audits of providers' cost reports, financial records and other pertinent documents must be adequate to verify -

(1) That the provider has included only those expense items that the agency has specified as allowable costs under § 447.278 in compiling the costs of services.

* * * * * * * *

(5) That the provider is complying with the requirements of § 405.1121(m) of this chapter if a skilled nursing facility or § 442.311(e) and § 442.406 of this chapter if an intermediate care facility, regarding protection of patients' funds.

§ 447.295 Audit report.

(a) Upon conclusion of each audit under § 447.292 the auditor must submit an audit report to the agency.

(b) The report must meet generally accepted auditing standards.

(c) The report must state the auditor's opinion as to whether, in all material respects, the cost report submitted by the provider under § 447.274 complies with § 447.294(b)(1) and (2).

(d) The agency must keep audit reports for at least 3 years after receipt.

§ 447.296 Accounting for overpayment found in audits.

The agency must account for overpayments found in audits on the quarterly statement of expenditures no later than the second quarter following the quarter in which the overpayment was found. (See 45 CFR 201.66 for accounting for overpayments.)

Payment Determination

§ 447.301 Methods and standards for setting reasonable cost-related payment rates.

(a) The plan must set forth the methods and standards used by the agency to set reasonable cost-related payment rates.

(b) The methods and standards must be developed by the agency on the basis of cost-

finding methods approved under § 447.276.

(c) The agency must set payment rates on the basis of the methods and standards. The payment rates must be effective no later than January 1, 1978.

§ 447.302 Actual Costs.

(a) Methods and standards for determining payment rates must reasonably take into account actual costs of the allowable items set forth in §§ 447.278 through 447.284, reported under § 447.274 and as verfied by audits under §§ 447.292 and 447.293.

(b) Payment rates must not be set lower than rates that the agency reasonably finds to be adeqaute to reimburse in full the actual allowable costs of a facility that is economically and efficiently operated.

§ 447.303 Economic conditions and trends.

The methods and standards for determining payment rates must reasonably take into account economic conditions and trends during the period for which the rates are set.

§ 447.304 Redetermination of prospective payment rates.

Prospectively determined payment rates must be redetermined at least annually.

§ 447.305 Class rate determination.

If payment rates are determined for a class of facilities, the plan must set forth reasonable criteria for the class and the methods and standards for determining the rate of payment for the class.

§ 447.306 Retroactive downward adjustment provisions.

(a) If facilities are classed by quality of services or level of care and the payment rates provide for adjustment to a prospectively set lower rate for facilities with service deficiencies, the plan must set forth the service deficiencies for which payment may be adjusted to the lower rate.

(b) A ratesetting method that provides for adjustment downward to a prospectively set lower rate is not subject to the upper limits

under § 447.316.

(c) If proposed rates or rate formulas provide for retroactive downward adjustments, the agency, in publishing the proposed rates or rate formulas for public comment, under § 447.205, must state the deficiencies under which an adjustment would be made and the amount or percentage rate of the adjustment.

NEW YORK STATE PUBLIC HEALTH LAW

§2808. Residential health care facilities; rates of payment

1. a. The commissioner shall promulgate interim regulations to expire no later than the thirty-first day of December, nineteen hundred seventy-six, that will relate the rate of payment for each residential health care facility to the operation and program management of the facility, as well as to the quality of patient care provided by the facility. Such regulations shall be consistent with regulations promulgated under the provisions of title eighteen of the federal social security act, by which payment for costs incurred by a residential health care facility for a quantity and quality of supplies or services necessary for the proper operation of a residential health care facility shall not exceed those which would be paid in the normal course of business by a prudent buyer of such supplies or services.

b. The commissioner shall promulgate interim regulations regarding real property costs to expire no later than the thirty-first day of December, nineteen hundred seventy-six, which shall be applicable to all residential health care facilities, regardless of the form of ownership of the facility, and shall be based upon a cost valuation basis of the facility as determined by the commissioner, who may disregard any and all prior transactions involving the property which are not bona fide and arm's length transactions. The commissioner shall consider such factors as the age, size, location and condition of the facility.

c. The commissioner shall submit recommendations to the governor, president pro tem of the senate and speaker of the assembly by the first day of February, nineteen hundred seventy-six, on proposed legislation which will relate the rate of payment for each residential health care facility to the operation and program management of the facility, as well

as to the quality of patient care provided by the facility. The commissioner shall further submit recommendations to the governor, president pro tem of the senate and the speaker of the assembly by the first day of February, nineteen hundred seventy-six, for the establishment of a reimbursement system for the construction costs and real property value of existing residential health care facilities and new residential health care facilities which will take into consideration all factors including location of the facility, age, size and depreciation as well as a formula to be established for the bona fide transfer and sale of residential health care facilities on and after the first day of February, nineteen hundred seventy-six.

2. (a) The commissioner, with the approval of the state hospital review and planning council, shall promulgate regulations to be effective the first day of January, nineteen hundred seventy-eight, relating the rate of

payment for each residential health care facility to real property costs.

(b) Such regulations may differentiate based upon the form of ownership of the facility, and shall provide for consideration of such factors as the age, size, location and condition of the facility.

(c) For facilities granted operating certificates prior to March tenth, nineteen hundred seventy-five, the real property costs shall be computed upon a cost valuation basis of the facility as determined by the commissioner, who, subject to the approval of the director of the budget, may provide exceptions in circumstances where he finds that application of the regulations would result in excessive reimbursement or in severe economic hardship to the facility not caused by circumstances reasonably under the control of the facility.

(d) For facilities granted operating cer-

ificates on or after March tenth, nineteen hundred seventy-five, recognition of real property costs in such regulations shall be based upon historical costs to the owner of the facility, provided that payment for real property costs shall not be in excess of the actual debt service, including principal and interest, and payment with respect to owner's equity. For purposes of this subdivision, owner's equity shall be calculated without regard to any surplus created by revaluation of assets and shall not include amounts resulting from mortgage amortization where the payment therefore has been provided by real property cost reimbursement.

(e) All transactions, including leases and mortgages, which are not bona fide and reasonable shall be disregarded.

2-a. (a) The commissioner, with the approval of the state hospital review and planning council, shall promulgate regulations to

be effective the first day of January, nineteen hundred seventy-nine, relating the rate of payment for each residential health care facility to real property costs.

(b) Such regulations may differentiate based upon the form of ownership of the facility, and shall provide for consideration of such factors as age, size, location and condition of the facility.

(c) For facilities granted operating certificates prior to March tenth, nineteen hundred seventy-five, the real property costs shall be computed upon a cost valuation basis of the facility as determined by the commissioner, who, subject to the approval of the director of the budget, may provide exceptions in circumstances where he finds that application of the regulations would result in excessive reimbursement or in severe economic hardship to the facility not caused by circumstances reasonably under the control of the facility.

(d) For facilities granted operating certificates on or after March tenth, nineteen hundred seventy-five, recognition of real property costs in such regulations shall be based upon historical costs to the owner of the facility, provided that payment for real property costs shall not be in excess of the actual debt service, including principal and interest, and payment with respect to owner's equity. For purposes of this subdivision, owner's equity shall be calculated without regard to any surplus created by revaluation of assets and shall not include amounts resulting from mortgage amortization where the payment therefor has been provided by real property cost reimbursement.

(e) All transactions, including leases and mortgages, which are not bona fide and reasonable shall be disregarded.

3. The commissioner, with the approval of the state hospital review and planning

council, shall promulgate regulations to be effective the first day of January, nineteen hundred seventy-eight, which shall relate the rate of payment to the efficient operation and program management of the facility, as well as to the quality of patient care provided by the facility. Such regulations shall be consistent with the requirements of subdivision three of section twenty-eight hundred seven of this chapter and with federal laws and regulations.

4. The commissioner, in determining and certifying to the director of the budget the rates of payment to residential health care facilities, shall exclude the following costs: (a) contributions or other payments to political parties, candidates or organizations; (b) direct or indirect costs incurred for advertising or promotion except as allowed by the commissioner; (c) costs incurred for the promotion or opposition, directly or indirectly, of the passage of bills or resolutions pend-

ing before or passed by a legislative body of any jurisdiction; (d) costs which principally afford diversion, entertainment or amusement to their owners, operators or employees not properly related to patient care or treatment; (e) any penalty imposed by governmental agencies or courts, and the costs of policies obtained solely to insure against the imposition of such a penalty; and (f) costs incurred by the residential health care facility to obtain the security required under the provisions of section twenty-eight hundred nine of this chapter.

5. Any operator withdrawing equity from a facility so as to create or increase a negative net worth, calculated without regard to any surplus created by revaluation of assets, must obtain the prior approval of the commissioner in accordance with regulations promulgated by the commissioner with the approval of the state hospital review and planning council. No facility shall enter into

a real property mortgage or lease transaction without thirty days prior notice in writing to the commissioner.

6. Prior to the approval by the state hospital review and planning council of any regulations promulgated pursuant to this section, the commissioner shall convene a public hearing, upon at least seven days notice, to consider the proposed regulations. The commissioner shall include a summary of the comments made at such hearing in a report to the state hospital review and planning council at the meeting at which it considers the regulations for approval.

TITLE 10

NEW YORK CODE OF RULES

& REGULATIONS

SUBPART 86-2

RESIDENTIAL HEALTH CARE FACILITIES

§86-2.19 Depreciation for voluntary and public residential health care facilities.

(a) Reported depreciation based on approved historical cost of buildings, fixed equipment and capital improvements thereto is recognized as a proper element of cost for voluntary and public residential health care facilities. Useful lives shall be the higher of the reported useful life or those from the Estimated Useful Lives of Depreciable Hospital Assets, American Health Association, copyright 1973.

(b) In the computation of rates effective for voluntary residential health care facilities, depreciation shall be included on a straight line method on plant and non-moveable equipment. Depreciation shall be funded unless the Commissioner of Health shall have determined, upon application by the residential health care facility, and after having written comments from interested parties, that the requested waiver of the re-

quirements for funding is a matter of public interest and necessity. In instances where funding is required, such fund may be used only for capital expenditures with approval as required or for the amortization of capital indebtedness.

(c) In the computation of rates for public residential health care facilities, depreciation is to be included on a straight line method on plant and non-moveable equipment.

(d) Residential health care facilities by mortgage loans pursuant to the Nursing Home Companies Law or the Hospital Mortgage Loan Construction Law shall conform to the requirements of this Subpart. In lieu of depreciation and interest, on the loan financed portion of the facilities the State Commissioner of Health shall allow level debt service on the mortgage loan, together with such required fixed charges, sinking funds and reserves as may be determined by the commissioner as necessary to assure repayment of the mortgage indebtedness.

(e) In the computation of rates for voluntary residential health care facilities which are rented from proprietary interests, the provisions of section 86-2.21 of this Subpart shall apply, except where the realty was previously owned by the voluntary residential health care facility or where the proprietary interest has representation on the board of directors of the voluntary residential health care facility.

(f) In the event that a residential health care facility is sold or leased or is the subject of any other realty transaction, the capital cost component of such rate shall be considered to be continuing with the same force and effect as though such sale, lease or other realty transaction has not occurred.

§86-2.20 Interest for voluntary and public residential health care facilities.

(a) Necessary interest on both current and capital indebtedness is an allowable cost

for voluntary and public residential health care facilities.

(b) To be considered as an allowable cost, interest shall be incurred to satisfy a financial need, and at a rate not in excess of what a prudent borrower would have had to pay in the money market at the time the loan was made. Also, the interest shall be paid to a lender not related through control, ownership, affiliation or personal relationship to the borrower, except in instances where the prior approval of the Commissioner of Health has been obtained.

(c) Interest expense shall be reduced by investment income with the exception of income from funded depreciation, qualified pension funds, or in instances where income from gifts or grants is restricted by donors. Interest on funds borrowed from a donor restricted fund or funded depreciation is an allowable expense.

(d) Interest on current indebtedness shall be treated and reported as an operating administrative expense.

(e) Interest on capital indebtedness, as defined in paragraph 86-2.21(a)(1) of this Subpart is an allowable cost if the debt generating the interest is approved by the commissioner, incurred for authorized purposes, and the principal of the debt does not exceed either the approval of the commissioner or the cost of the authorized purposes. Interest related to refinancing indebtedness shall be considered an allowable cost only to the extent that it is payable with respect to an amount equal to the unpaid principal of the indebtedness then being refinanced. However, interest incurred on refinanced debt in excess of the previously unpaid balance of the refinanced indebtedness will be allowable on acceptable demonstration to the Commissioner of Health that such refinancing will result in a debt service savings over the life of

the indebtedness.

§86-2.21 Capital cost reimbursement for proprietary residential health care facilities.

(a) Definitions. As used in this section, the following terms shall be defined as follows:

(1) Capital indebtedness. The term capital indebtedness shall mean all debt obligations of a facility that are:

(i) evidenced by a mortgage note or bond and secured by a mortgage on the land, building or nonmoveable equipment of a facility or evidenced by a note incurred in accordance with subparagraph (ii) of this paragraph;

(ii) incurred for the purpose of financing the acquisition, construction or renovation of land, building or nonmoveable equipment (hereinafter called the "authorized purpose"); and

(iii) found by the commissioner to be

reasonable, necessary and in the public interest with respect to the facility in accordance with standards set forth in section 86-2.21(e)(3)(ii) of this Subpart. Refinancing of capital indebtedness shall be recognized only to the extent of the then unpaid balance of the debt being refinanced.

(2) Commissioner. The term commissioner shall mean the Commissioner of Health of the State of New York.

(3) Department. The term department shall mean the Department of Health of the State of New York.

(4) Equity. The term equity shall mean all cash or other assets, net of liabilities, invested by a facility or its operator in land, building and nonmoveable equipment, and found by the commissioner to be reasonable, necessary and in the public interest with respect to the facility. Equity shall

not include any change in the book value of a facility resulting from revaluation of assets or from the amortization of capital indebtedness resulting from payments made pursuant to subdivision (e) paragraph (3) of this section.

(5) Facility. The term facility shall mean a proprietary residential health care facility, as the term residential health care facility is defined in article 28 of the Public Health Law and in regulations of the department.

(6) Inital allowed facility cost. The term initial allowed facility cost shall mean the portion of certified costs approved by the commissioner, or in the case of facilities granted operating certificates prior to April 15, 1973, the costs of the facility as verified by audit to the satisfaction of the commissioner, or in the case of facilities not able to comply with either of the foregoing

standards, costs imputed pursuant to subdivision (g) of this section, in or prior to the first year of useful facility life attributable to the acquisition of land and the construction, acquisition or renovation of building and nonmoveable equipment. The commissioner shall disregard any costs relating to prior transactions involving the facility which he finds were not bona fide or the terms of which are found to be other than fair and reasonable.

(7) Useful facility life. The term useful facility life shall mean a period of 40 years measured from the calendar year in which a facility commences operations as determined by the commissioner.

(8) Rate of return. The term rate of return shall mean the annual rate of return on equity invested, as said rate is determined by the United States Department of Health, Education and Welfare as an element of reason-

able cost for purposes of payments to or reimbursement of proprietary providers under title XVIII of the Federal Social Security Act.

(9) Capital improvement. The term capital improvement shall mean any addition to, replacement of, or improvement of a capital item of plant or nonmoveable equipment approved by the commissioner as reasonable, necessary and in the public interest.

(10) Capital improvement cost. The term capital improvement cost shall mean the actual expenditure or portion thereof attributable to a capital improvement approved by the commissioner as reasonable, necessary and in the public interest.

(11) Hospital-based residential health care facility. The term hospital-based residential health care facility shall mean a facility holding a certificate of operation as a residential health care facility which is wholly owned by a hospital as

that term is defined in Subpart 86-1 of this Title, and is physically located in a building or buildings, part of which building or buildings are also used for provision of acute care hospital services.

(12) Effective term. The term effective term shall mean the number of years and months required, pursuant to the term of the note or mortgage, to fully amortize the principal of the debt, predicated upon the regular principal payments required by the mortgage or note, but determined without regard to any provision for making the balance all due and payable at a given date or upon a stated event, and without regard to any provision for acceleration of the debt or any original or subsequent agreement for the suspension or moratorium of principal payments.

(b) Subject to the subdivision (f) of this section, the reimbursement rate of every facility certified by the commissioner and ap-

proved by the State Director of the Budget pursuant to article 28 of the Public Health Law shall, in each year of useful facility life, include a capital cost component determined in accordance with the provisions of subdivision (c), (d) or (e) of this section applicable to the facility in such year.

(c)(1) The provisions of subdivision (e) of this section shall not apply for the term prescribed by paragraph (3) of this subdivision to any facility which, as of the effective date of this section, is located in and operated from leased space pursuant to a lease:

(i) which was entered into andapproved for reimbursement prior to March 10, 1975; and

(ii) which the commissioner finds to be bona fide, valid and noncancelable; and

(iii) the payments, or a portion thereof, made pursuant to such lease are found by the commissioner to have been the proper basis for reimbursement of capital cost paid to

such facility pursuant to article 28 of the Public Health Law prior to March 10, 1975.

(2) The capital cost component of a facility within the provisions of paragraph (1) of this subdivision shall, for the term prescribed by paragraph (3) of this subdivision, consist of a payment factor sufficient to reimburse the facility for the total payments required under its lease to the extent approved by the commissioner pursuant to paragraph (1) of this subdivision, and subject to the historical limitations set forth by the commissioner.

(3) Capital cost reimbursement for leased facilities shall be made pursuant to this subdivision for the balance of the lease term (computed without regard to any future extension or option to renew authorized by the lease) remaining as of the effective date of this subdivision. Upon the expiration of such balance of the lease term provided in an ap-

proved lease (as said lease so provides as of August 1, 1977) or such earlier expiration date as may be agreed to by the parties to an approved lease, capital cost reimbursement shall be made pursuant to subdivision (e) of this section notwithstanding any extension or renewal of such lease or the execution of a new lease by or on behalf of the facility; provided, however, that the commissioner may, in his discretion, continue capital cost reimbursement for such leased facilities pursuant to this subdivision, at a rental amount approved by the commissioner prior to such extension or renewal, and not pursuant to subdivision (e), upon his finding that there is a public need for such facility at the time and place and under the circumstances proposed and that the continued operation of such facility would be jeopardized by a limitation of reimbursement pursuant to subdivision (e).

(d) The provisions of subdivision (e) of this section shall not apply to hospital-based

residential health care facilities. Such facilities will be reimbursed pursuant to capital cost regulations in Subpart 86-1 of this Part.

(e)(1) Subject to the provisions of subdivisions (c), (d) and (f) of this section, the capital cost component for every facility shall consist of the payment factors provided in this subdivision that, in any year of useful facility life, are applicable to the facility.

(2) Interest. The capital cost component shall, in each year of useful facility life, include a payment factor sufficient to reimburse, at a rate which the commissioner finds to be reasonable under the circumstances prevailing at the time of the placing of the capital indebtedness, interest on capital indebtedness.

(3) Amortization. (i) Subject to the limitations of paragraph (5) of this subdivision, the capital cost component shall, in

each year of useful facility life, include a payment factor sufficient to reimburse the amortization component of capital indebtedness pursuant to the terms of the mortgage note or bond.

(ii) The capital indebtedness of a facility, to the extent that the original principal of such debt does not exceed the initial allowed facility cost of the facility, shall be recognized as follows:

(a) For capital indebtedness with an effective term of 10 years or less, amortization expense will be recognized for the purpose of reimbursement only, if the schedule of debt amortization is within the limitation set forth in section 86-2.21(e)(5) of this Subpart for each of the years of debt amortization.

(b) For capital indebtedness with an effective term in excess of 10 years, amortization expense will be recognized for the purpose of reimbursement upon a determination by the commissioner that the following stan-

dards are met:

(1) the debt is incurred for authorized purposes;

(2) the interest rate is reasonable for the time and place in which the capital indebtedness is committed, and for the type of indebtedness associated with the interest rate;

(3) the amortization schedule is reasonable (amortization must be required in each year of the mortgage in accordance with the established financial practices);

(4) the effective term is consistent with customary commercial practices in the geographic area of the facility; and

(5) the effective term is in accordance with efficient production of services.

(c) For capital indebtedness other than first mortgages, the amortization expense will be recognized for the purpose of reimbursement upon a determination by the commissioner that the debt, complies with the standards set forth

in section 86-2.21(e)(3)(ii)(b) of this Subpart, and the following additional standards:

(1) they must be incurred for the purpose of financing either an approved purchase or construction of a facility; and

(2) the effective term of financing for a capital improvement is reasonable when compared to the estimated useful life of the improvement.

(d) Capital indebtedness for any unauthorized purpose will not be recognized for any reimbursement purpose.

(4) Return of equity. Subject to the limitations of paragraph (5) of this subdivision, the capital cost component shall include a payment factor sufficient to return equity. A facility shall be eligible for the return of equity commencing in the first year following the department's determination, among other factors, that the facility has the ability to meet current capital indebtedness (including prin-

cipal and interest) over the balance of useful facility life. This shall mean that within the confines of the regulations expressed in this Subpart, capital reimbursement will be sufficient to provide for the remaining amortization of capital indebtedness. The commissioner's determination shall also take into account such factors as the age, size, location and condition of the facility, and the financial condition of the facility.

(5) Limitation. Annual reimbursement payments for capital cost under paragraphs (3) and (4) of this subdivision shall not at any time result in a cumulative average payment in excess of two and one-half percent of initial allowed facility cost. For years prior to 1978, actual amortization or depreciation paid by Medicaid will be used in the computation of the limitation. For years prior to Medicaid or in years when Medicaid payments did not include an expense equivalent of depreciation or

amortization, a two and one-half percent payment will be imputed.

(6) Return on equity. The capital cost component for every facility shall include a payment factor sufficient to pay an annual rate of return on average equity, as such average annual equity shall be determined by the commissioner in each year of useful facility life.

(7) Residual reimbursement. After the expiration of useful facility life, the commissioner may approve a payment factor for any facility for which he determines that contined capital cost reimbursement is appropriate; provided, however, that such payment factor shall not exceed one half of the capital cost reimbursement received by such facility in the final year of useful facility life.

(8) Capital improvement cost reimbursement. (i) The capital improvement cost shall be reimbursed by adjusting the initial allowed

facility cost, capital indebtedness, equity determinations and limitations as stated in paragraph (5) of this subdivision, to include the capital improvement cost.

(ii) Adjustment in accordance with subparagraph (i) of this paragraph shall be made in the following manner:

(a) if the cost of an improvement is $100,000 or more, and certificate of need approval has been granted by the commissioner, then component useful life for the improvement will be permitted. Such component useful life will be equivalent to the estimated asset life in accordance with the Medicare Provider Reimbursement Manual or the remaining useful life of the facility, whichever is less. Where a capital improvement adjusts the expected life of the facility beyond the remaining portion of the original useful life facility life, the limitation set forth in section 86-2.21(e)(5) of this Subpart, will be increased to allow for the reimbursement of the amortization component

of the debt obtained to finance the improvement.

(b) If the cost of an improvement is less than $100,000, then the cost will be reimbursed over the remaining portion of the expected useful life. In such instances the reimbursement will commence with either the reporting of such costs on an annual certified cost report or, upon submission of a cost report, certified by an independent public accountant, whichever is submitted first. In either event, the reporting of such costs must be accompanied by a sworn statement by the administrator or the chief fiscal officer of the facility to the effect that the improvements made are not part of a number of planned related projects which, in the aggregate, total $100,000 or more.

(c) If the cost of an improvement is less that $100,000 and:

(1) is undertaken as the result of an

emergency situation;

(2) affects the health and safety of the patients, and;

(3) the facility can demonstrate dire financial condition; then the limitation set forth in section 86-2.21(e)(6) of this Subpart will be modified to allow for the reimbursement of the debt service associated with the financing of the approved capital improvement over the effective term of the obligation or five years, whichever is greater. Any contribution to the improvement by the facility and not financed by the debt obligation will be considered an equity contribution and an adjustment to the facility's total capital equity will be made.

(d) If a facility undertakes an authorized improvement without incurring additional debt, then the facility will receive a return on equity and, when a determination has been made in accordance with section 86-2.21(e)(4) of this Subpart, a return of equity, for the

funds invested in the improvement.

(f)(1) With respect to facilities granted operating certificates prior to March 10, 1975, the commissioner may modify or provide exceptions to subdivision (c) or (e) of this section in circumstances where he finds that application of the provisions of either subdivision would result in (i) excessive reimbursement of the facility, or (ii) severe economic hardship to the facility not caused by circumstances reasonably under the control of the facility. In determining severe economic hardship, the commissioner shall consider such factors as debt service required on capital indebtedness, prior withdrawal of assets from the facility, and the financial condition of the facility in general. In such cases where the commissioner makes a finding of severe economic hardship, the capital cost component of the rate shall not exceed the debt service on capital indebtedness.

(2) The commissioner may revise the capital cost component of the reimbursement rate applicable to any facility which he determines is based upon previous error, or deceit or any other misrepresentation or misstatement by the facility.

(3) The capital cost component shall not be affected by any sale, lease or transfer occurring after March 10, 1975.

(g) In lieu of determining initial allowed facility cost pursuant to subdivision (a) of this section, the commissioner may estimate the original fair and reasonable cost of the facility with due regard for the fair and reasonable cost of facilities of comparable age, size, location and condition, and impute an initial allowed facility cost to:

(1) every facility for which records on the historical cost or book value of land, building or nonmoveable equipment are not avail-

able or not verifiable to the statisfaction of the commissioner;

(2) every leased facility which, as of the effective date of this section, is not eligible for reimbursement pursuant to subdivision (c) of this section;

(3) every facility which, after the effective date of this section, ceases to be eligible for reimbursement pursuant to subdivision (c) of this section and becomes eligible for reimbursement pursuant to subdivision (e) of this section; or

(4) every facility whose construction was completed prior to the calendar year in which this section becomes effective and whose initial facility year occurs in or after the calendar year in which this section becomes effective.

(h) In the event that a facility fails to submit information necessary for the im-

plementation of this section, after notification pursuant to subdivision (f) of section 86-2.2 of this Subpart, the capital cost component of the rate shall consist of interest, if reported, and amortization not in excess of the lesser of the amortization payment required under capital indebtedness, or two and one half percent of initial allowed facility cost.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

August 13, 1981

Mr. Brook Chambery
Beechwood Nursing Home
900 Culver Road
Rochester, New York 14609

Dear Mr. Chambery:

This is in response to your Freedom of Information request for a copy of the "Standardized Review Criteria for Title XIX Long-Term Care Payment Plans," which this Bureau prepared for the Fifth Circuit Court of Appeals. Enclosed is a copy of the draft document; there is no charge for it.

We would like to point out that as the issues and circumstances surrounding the Florida and Alabama cases are particular to the Fifth Circuit and a Fifth Circuit decision does not extend beyond its

jurisdiction, the review criteria are only applicable in these two cases. Further, that the enclosed document is a draft copy which, as the term implies, was prepared in response to the specific cases which are still pending in the courts. It is not an official HCFA review guide and is not intended as such.

Also, the review criteria will require substantial modification as a result of Section 962 of the Omnibus Reconciliation Act of 1980 (Public Law 96-499), effective October 1, 1980, which amends Section 1902(a)(13)(E) of the Social Security Act (i.e., reimbursement rates under Medicaid for skilled nursing and intermediate care facilities).

Sincerely yours,

Peter Bouxsein
Director
Bureau of Program Policy

Enclosure

DRAFT

Standardized Review Criteria for Title XIX Long-Term Care Payment Plans

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I. Introduction

A. General

The following review criteria present an analytical approach to reviews of State reimbursement plan methodologies for long-term care facility services under the Medicaid program. This review process reflects Federal statutory and regulatory requirements which must be met before such plans can be approved for Federal financial participation. These criteria provide the minimal framework within which the States are to develop the methods and standards of Medicaid reimbursement for long-term care facility services, yet leave the required latitude in the development

of an overall plan of payment for those services.

B. State Medicaid Reimbursement Systems

The individual methods of reimbursement used by the States to establish long-term care facility payment rates under the Medicaid program are characteristically diverse. Some States adhere closely to the Medicare program principles of reimbursement for definitional purposes, while others develop alternative reimbursement principles. For example, some States have adopted the Medicare cost principles under Provider Reimbursement Manual 15 (HIM-15) while others develop their own cost principles and definitions. Some States base individual facility payment rates upon each

facility's individual cost characteristics while others pay the same rate to all comparably certified facilities. Some States base payment rates upon actual current period operating costs while others employ some type of forecasting methodology. Although there are many different reimbursement methodologies, and the general examples cited here are not all inclusive, most State ratesetting methods can generally be categorized as being either retrospective or prospective. However, some States can and do utilize a ratesetting methodology which employs elements of both a retrospective and a prospective system.

Under a retrospective system, institutions are reimbursed for the costs

they actually incur to the extent such costs are allowable and reasonable. Interim payment rates are developed based upon reasonable cost data and are subjected to a final retroactive year-end adjustment process. While retrospective costs are generally determined on an individual facility basis, this concept is not a requirement for a retrospective system.

Prospective reimbursement systems establish a payment rate in advance of a cost year by adjusting a previous period's cost to reflect the change in economic conditions up to and including the rate period. Such systems basically project (forecast) base period costs into a future period through the use of indexing methodologies. Prospective payment

rates may be developed from several sources, including historical and budgeted costs and may be established by a State regulatory office, or a ratesetting commission. Federal statute requires that the rates must be developed on a reasonable cost-related basis and be conducive to efficiency, economy, and quality of care. Such rates must be redetermined at least annually. However, the requirement that States use a cost-related system does not require them to reimburse each facility an amount determined by the facility's own accounted costs. Prospective rates can be related to or independent of the costs of a particular facility. A uniform rate may be paid to all facilities in a class, or the rate may vary, facility by facility.

C. Statutory and Regulatory Basis

-- Statutory:

- Section 1902(a)(13)(E) of the Social Security Act (42 USC 1396(a)(13)(E))

- Section 1902(a)(30) of the Social Security Act (42 USC 1396a(30))

Section 1902(a)(13)(E) of the Social Security Act mandates that a State plan for medical assistance must provide for payment of skilled nursing facility and intermediate care facility services provided under the plan on a reasonable cost-related basis, as determined in accordance with methods and standards which shall be developed by the State on

the basis of cost finding methods approved and verified by the Secretary.

Section 1902(a)(30) of the Social Security Act mandates that a State plan for medical assistance must provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are not in excess of reasonable charges consistent with efficiency, economy, and quality of care.

-- Regulatory

o	Payment Assurances	Regulations 447.311
o	Upper Limits	Regulations 447.315-447.316

II. Reasonable Cost-Related Payment Rate

The regulations (447.301) mandate that the State plan set forth the methods and standards used by the State to set reasonable cost-related payment rates. The regulations (447.302) also mandate that these payment rates must be set at a level the State reasonably finds to be adequate to reimburse in full the actual allowable costs of a facility that is economically and efficiently operated.

The judgement involved in plan approvability can only be looked upon as the concluding episode of

- 42 CFR 447.273 - 447.316 Reasonable cost-related basis for long-term care facility services.

42 CFR 447.273 requires that the Medicaid agency must pay for long-term care facility services on a reasonable cost-related basis in accordance with 42 CFR 447.274 through 447.311.

42 CFR 447.274 through 447.316 are organized around five general areas of State plan requirements established by the above statute and amplified by the legislative history:

o Cost Finding and Reporting	Regulations 447.274-447.284
o Audits	Regulations 447.290-447.296
o Payment Determination	Regulations 447.301-447.306

the entire review process. The judgements as to acceptability of the "cost-relatedness" of the plan are predicated upon criteria concerning cost definitions, cost allowability, cost reporting, and indexing. As will become evident upon following this review guide, once these elements have been reviewed in detail in accordance with the criteria, the judgement as to the cost-relatedness of the plan becomes apparent.

Similarly, the criteria against which we judge "efficiently and economically operated" are related to several review areas; and, as required in regulations, a judgement is made as to whether the findings of the State agency <u>reasonably</u> assure that the rates are adequate

to reimburse in full the actual allowble cost of these efficiently and economically operated facilities. The Federal responsibility is to review and accept or reject the reasonableness of the State's findings. The statute and regulations do not contemplate that the Secretary will make judgement as to what the State should do, but rather, the Secretary will judge the reasonableness of the State's decision. As noted throughout the review guide, these findings by the Secretary do not manifest themselves in the judgement surrounding a single statement by the State giving assurances of reimbursing the actual allowable cost of an efficiently and economically operated provider. Rather, the Secretary's determination is made upon the comprehensive

judgement reached concerning every individual element of the plan and every element's interaction with each other. As noted above, the detailed objective criteria concerning cost reporting, cost finding, audits, cost allowability, reasonableness criteria, ratesetting methods, classification procedures, indexing and forecasting and other plan provisions which affect the reimbursement rate ultimately developed are the basis for this judgment.

The sum total of the plan review process, including initial review, dialogue with the State, review of justifying and substantiating data, lead the Federal reviewers to the dual conclusions required by statute that the plan be reasonable

cost-related and pays rates no lower than the State reasonably finds adequate to reimburse in full the actual allowable cost of an efficiently and economically operated provider. Neither the States, in plan development, nor the Health Care Financing Administration, during plan review, are required to conduct individual facility reviews and analysis surrounding individual facility data before reaching the judgement of plan approvability.

As an attachment to the review guide are two exhibits that will become the functional framework and documentation for State plan review. Exhibit A is a checklist for State plan payment methodologies for long-term care services. This checklist follows the Federal regu-

latory format in reviewing individual State plan elements concerning cost reporting, cost finding, audits, payment determinations, payment assurances, upper limits on payments and public notice requirements. Exhibit B is a "side by side" analysis of a particular State long-term care reimbursement plan and any proposed amendment. The "side by side" analysis lists 19 areas of reimbursement procedures that must be reviewed, highlighted and comprehended before any judgement can be concluded on plan approvability. These two documents are to be completed for each State plan review and become the foundation upon which a reasonable cost related reimbursement judgement can be based.

III. Cost Finding and Reporting (447.274 through 447.284)

A. Reporting Requirements (447.274). The regulations mandate that the State plan require providers to submit a cost report to the State within 3 months after the close of a provider's reporting period. In order for the reimbursement to be on a reasonable cost-related basis, the cost report must provide for determining allowble costs, cost-finding, and cost-apportionment.

While each State may design its own report, there are certain criteria which must be met:

1. The cost report must be uniform for all SNFs and uniform for all ICFs; however, the same report

may be used by both SNFs and ICFs (the same rule also applies to ICFs/MR).

2. The cost report must include:

   a. an itemized list of the provider's allowable costs,

   b. a list of the various services provided for under the plan, and

   c. a cost-finding methodology.

3. Reported costs must be based on generally accepted accounting principles and the accrual method of accounting. However, the cash method of accounting is acceptable for public institutions (447.274(c)).

4. The cost report must identify related organizations and the costs incurred in transactions with related organizations (447.284). Costs of services, facilities, and supplies furnished by organizations related to the provider by common ownership or control must not exceed the lower of the costs incurred by the related organization or the price of comparable services, facilities, or supplies purchased elsewhere.

The State plan must also specify the inclusive dates of the cost-reporting year and the beginning date of the first reporting year (which may be no later than Janury 1, 1977). The cost-reporting year need not be the same for all providers (447.275).

The plan must specify any requirements that permit an extension of time in submission of cost reports.

B. Cost-Finding (447.276). The State plan must specify the cost-finding methods to be used by providers. Cost-finding is defined to be a process of recasting the expense data from the provider's accounting records in order to determine the costs of each type of service by allocating direct costs and prorating indirect costs. The purpose of a method of cost-finding is to determine the full cost (direct and indirect) of routine revenue producing departments, ancillary revenue producing departments, and other activity costs for which reimbursement is not allowed under Medicaid.

The regulations require a uniform cost-finding method for all SNFs and a uniform method for all ICFs, although the same cost-finding method may be used by both SNFs and ICFs. In addition, since ICFs/MR are sufficiently different from general IFCs, States are permitted to employ different cost-finding methodologies for these facilities. However, the cost-finding method must be uniform for all ICFs/MR (it may be the same as the method used for SNFs and/or ICFS).

As a subpart of the cost-finding process, a provider's costs must also be subjected to an apportionment process, which must be detailed in the State plan. The purpose of a method of apportionment is to determine that portion of a provider's

costs which are attributable to furnishing services to Medicaid recipients.

The Regional Medicaid Director, with the concurrence of the central office, must review and approve the cost-finding method used by the State; however, if Medicare cost-finding as specified in 42 CFR 405.453(d) is used, the approval will be automatic.

C. Allowable Cost (447.278 through 447.283). The State plan must specify the items of provider expense that are allowable costs. The plan must also specify how the reasonableness of allowable costs will be determined, since reasonable costs are what are recognized under the Medicaid program for reasonble

cost related reimbursement. An allowable cost is an incurred expense, which by type is (1) necessary and proper, i.e., appropriate and helpful, to the development and maintenance of a long-term care facility and the patient care activities and services produced by that facility, and (2) a common and accepted occurrence in the long-term care facility industry. An allowable cost, however, may be unreasonable in amount. For example, the owner/administrator of an LTC facility may be receiving a yearly compensation of $100,000 for the services and functions he performs for the facility. Although administrator compensation costs are allowable in type, a State agency may determine that no long-term care facility should be incurring yearly compensa-

tion costs of $100,000 and therefore declare that such a yearly compensation cost is unreasonable in amount. Reasonable cost determinations are generally made upon desk review or upon audit of the provider's cost report. Reasonable cost determinations are limitations placed upon the full amount of individual costs that have been recognized as allowable in type.

As an alternative to defining all allowable cost principles, the plan may simply specify that the State will utilize the cost reimbursement principles under Medicare's Provider Reimbursement Manual (HIM-15) as a definition of allowable cost; or, the plan can specify Medicare's HIM-15 principles with exceptions. This is not to say that Medicare's

principles are the only way of defining allowable costs but rather, are a body of generally recognized and familiar principles to be used as a base point. A State has the prerogative to define allowable costs as it deems appropriate but such definitions must be reasonable. In determining the approvability of proposed definitions, consideration will be given as to whether the proposed definition (a) is reasonably cost-related and (b) is based on generally accepted accounting principles.

In order for a State plan to be found reasonable cost-related, it must address the following cost issues or items:

1. Include the cost of meeting provider certification standards, which means all expenses incurred by a provider to: (a) meet the Federal and State definition of SNF, ICF, or ICF/MR services, (b) comply with Federal SNF, ICF, or ICF/MR standards, (c) comply with requirements established by the State agency responsible for establishing and maintaining health standards, and (d) comply with any other requirements for licensing under State law that must be met to provide SNF, ICF, or ICF/MR services.

2. Include all costs incurred by facilities in providing routine services. The routine services listed at 42 CFR 447.281 are the

minimum routine care items and services which States must cover. The State may choose to add items, as covered services under its Medicaid SNF, ICF, or ICF/MR reimbursement rate.

3. Identify all ancillary services that are included in a provider's SNF, ICF, or ICF/MR rate.

4. Revenue offsets vs. expense recoveries must be clearly defined.

5. Capital costs must be defined and should include adequate descriptions of: (a) bases of depreciation (asset valuation), (b) methods of depreciation (c) asset lives, (d) recapture of gains on sale, and (e) capital

cost and capital cost limitations.

6. The plan must be specific and clearly justify the reasonable cost-relatedness of any cost ceilings, cost limitations, inflation factors, and occupancy factors.

7. A reasonable return on the equity capital invested and used in the provision of patient care may be included in the reasonable cost of the services furnished patients by proprietary providers. This return is the only item of profit that may be recognized as an allowble cost. Although the payment of a return on equity to proprietary providers is optional with each

State, the return should be related to the cost of attracting and maintaining capital investment in the State's long-term care industry. If the State decides to provide a return on owner's net equity of proprietary providers as an allowable cost, the State plan must specify the definition of net owner equity, the rate of return, and explain the calculation of the return allowance.

8. The State must specify the criteria for identifying those items which, though considered as an expense of business by the provider, may not be recognized for purpose of reimbursement. For example, the plan must identify revenue offsets which

cannot be recognized as an allowable cost. The regulations at 42 CFR 447.282 and 447.283 specify three types of revenue offsets that cannot be considered allowble costs: (a) bad debts, (b) charity allowances, and (c) courtesy allowances. Bad debts may only be recognized where they are attributed to deductible and copayment amounts imposed by the State on Medicaid patients (447.282).

9. Income taxes and other Federal, State, or local taxes predicated on the income of the provider are not an allowable cost since they are related to profit and should be so specified in the plan. Additionally, any interest or penalties imposed upon

such taxes are also not allowble costs and should be so specified.

D. Cost Report Detail Required. In order to determine allowable and reasonable costs, based on the regulatory criteria, the cost report should contain the necessary detail. Examples of such detail ar .

1. Certification. The cost report should contain a certifying statement by the provider that the report is true and accurate and was completed on the basis of State and Federal requirements.

2. Trial Balance. The cost report should contain a schedule for identifying and itemizing the provider's total cost and making

the adjustments and reclassifications necessary to conform with the State's allowable cost methodology.

3. Cost-Finding. The cost report should contain schedules that provide for the:

   a. distribution of the provider's indirect allowable costs to the various revenue producing services, and

   b. apportionment of the covered service costs for identifying the cost applicable to the program.

4. Lower of cost or customary charges. The cost report should contain a schedule that provides

for the computation of the lower of the cost applicable to Title XIX and the provider's customary charges for the services (see Section VII for discussion).

5. Return on Owner's Net Equity. If a State provides for a return on owner net equity for proprietary providers, the cost report should contain the following schedules:

   a. Balance sheet for computation of equity capital.

   b. A schedule for the computation and apportionment of return on equity capital.

6. Related Party Transactions. The cost report must identify related organizations and the cost of transactions with those organizations which are included in the cost report of the provider.

Note: Exemption from Audit Requirement: The Regional Medicaid Director, with concurrence of the HFCA central office, may exempt a State from the initial 3-year (at least one-third of the providers audited yearly) audit requirement, if (a) the State has a continuing audit program, (b) the State has completed onsite audits of the financial and statistical records of all providers during the 3 years pre-

ceding the end of the first cost-reporting period and (c) each onsite audit was conducted in accordance with generally accepted auditing standards and was sufficiently comprehensive in scope to determine that only proper items of cost applicable to Medicaid services were in the provider's calculation of its costs and whether expenses attributable to the items of cost were accurately determined and reasonable.

3. Continuing Audit: A requirement, under continuing audit provisions, that each subsequent year, the State must provide for onsite audit of the financial and statistical records of at least 15 percent of participat-

ing facilities. At least 5 percent must be selected at random and at least 10 percent must be selected by profiles of cost or other relevant factors.

Note: If a State receives an exemption from the "one-third a year" audit requirement (see "note" under #2 above), then the audit requirement that 15 percent of participating facilities be audited yearly applies beginning with the year after the first cost-reporting year.

4. Audit Standards: Audits must meet generally accepted auditing standards. The adoption of the audit standards in Medicare's HIM-13-2 and HIM-16 are recom-

mended but the agency may establish its own standards.

The audit standard provision contained in regulation 42 CFR 447.294 leaves States free to develop procedures for audit (acts to be performed) but specifies the required parameters of "standards" on the scope of the audit, qualifications of the auditors, degree of independence required of the auditor, the examination (planning, supervision, compliance with statute and regulations, internal control evaluation, adequacy of evidence and working paper requirements) and reporting.

Further, the State's audits of providers' cost reports, finan-

cial records, and other pertinent documents must be adequate to verify (a) that the provider has included only those expense items the State has specified as allowable costs in compiling the costs of services (b) that the provider has accurately determined allowable costs, and (c) that the provider's allowable costs are reasonable (447.294(b)).

B. Audit Reports (447.295)

1. Report submission: Upon completion of each audit, the auditor must provide a report to the State, giving the auditor's opinion as to whether the cost report, as submitted, complies with all State and Federal

requirements (see D2 below). The audit report must meet generally accepted auditing standards.

2. Audit Report Retention: The State must keep the audit report for at least 3 years after final settlement or determination.

C. Overpayments (447.296). The State must account for overpayments found in audits on the quarterly statement of expenditures (HCFA-64 Quarterly Statement of Expenditures Report), no later than the second quarter following the quarter in which the overpayments were found. "The quarter in which found" means the quarter during which the administrative hearing procedures of the State have been exhausted and a determina-

tion of overpayment has been sustained. It does not mean the date on which any related suit filed by the provider was completed.

An overpayment occurs any time some of the reported costs of a facility, which were used in setting a rate, (a) are found to be unallowable, and (b) impacts the rate that would have been paid to the provider had the costs not been overstated.

D. Audit Requirement Clarification. The following points will further clarify regulatory intent on audits:

1. To comply with audit requirements as specified in 42 CFR 447.292, States have the option to use their own staff or

independent auditors (contracted audit).

2. The opinion required by 42 CFR 447.295(c) need not be in accord with requirements of the American Institute of Certified Public Accountants; rather, the audit could be conducted according to the requirements specified by the State.

3. Desk audit (review) of provider cost reports is not sufficient to meet the requirements of audits specified in 42 CFR 447.292 through 447.293.

4. A State may require a longer retention period for provider records than the 3 years specified in 42 CFR 447.295.

V. Payment Determination (447.301 through 447.306)

A. Payment Methods and Standards (447.301 through 447.305). The State plan must set forth the methods and standards used by the agency to set reasonable cost related payment rates. The State's payment methodology must identify the overall payment options, or components thereof, as retrospective or prospective and provide details on the essential features in the rate development. The State plan must therefore, fully articulate the reimbursement methodology to afford a comprehensive understanding of how facility payment is determined.

The essential features of the payment methodology are allowable and

reasonable cost definitions, rate characteristics, classification criteria, State established payment ceilings, inflation indexing, occupancy factors, rate timing and methods of payment for ancillary service costs. Basically however, the payment methodology can be separated into two general components: (1) the determination of a provider's allowable costs and the evaluation of the reasonableness of these cost and (2) the rate setting methodology.

1. Allowable vs. nonallowable cost determinations can be made both on the provider cost report and by explicit action of the State agency. These determinations are made to distinguish costs allowed under the State's reim-

bursement principles from costs which are not reimbursable under the program (e.g., personal expenses on corporate books). Allowable cost determinations must be based upon the stated definitions of cost and the principles of reimbursement as articulated in the State plan. Such adjustments may be done via the cost report, upon desk review, upon audit or by specific reference in the plan document. In addition, the State agency may make further adjustments based upon tests of reasonableness. Reasonable cost adjustments may be done either at time of desk review or upon audit and may be based upon individual provider expenditure limitations (e.g.,

owner/administrator salary limits), reasonable cost/cost center screens (e.g., owner/adminstrator salary limits), reasonable cost/cost center screens (e.g., leasing and rental limitations or a capital cost screen based upon age of facility), or upon agency reveiw and determination of the facts and circumstances as to the appropriateness of either individual expenditures or a provider's categorical costs. For example, the State agency may conclude that certain provider expenditures such as the cost of using luxury automobiles and luxurious hotel/motel accommodations for business travel generate unreasonable business travel costs. To the extent

possible, reasonable cost guidelines and parameters should be fully specified in the plan; however, there will be instances of individual expenditures of individual or several providers which will require a judgement by the State agency as to the level of reasonableness of these expenditures. In addition, actual expenditure limits, such as administrative salary levels, which are imposed under reasonable cost guidelines must also be stated in the plan (see further discussion under C following).

2. After a reasonable cost base is determined from provider costs, the State employs a ratesetting methodology to determine a pro-

vider reimbursement rate. In most retrospective reimbursement systems, this reasonable cost base becomes the base upon which final retroactive settlement is made. In prospective reimbursement systems, this reasonable cost base is used to set future (prospective) reimbursement rates. In a prospective reimbursement system, the reasonable cost base is trended forward into a future rate setting period through the application of an indexing factor to determine what expected costs should be in such period (the prospective rate). Before addressing indexing however, a State's payment methodology needs to be identified by one or more of the following rate setting charac-

teristics which may apply to all or part of the reimbursement rate:

a. Individually determined facility rates. These rates are determined and paid to each facility based upon cost data from each individual facility and usually are subject to a defined ceiling.

b. Individual facility rates within a class. These rates are determined and paid to each facility based upon cost data from each individual facility. All facilities are then classed (grouped) by defined characteristics (see item B, this section) and an appropriate

group cost ceiling is determined.

c. Uniform class rates (flat rates). All facilities are classed (groupe) by defined characteristics and then paid the same rate within the class. The rate determination is usually based upon a selected percentile from an array of all provider's per diem costs in the class.

A State may also componentize a reimbursement rate by setting reimbursement limits by individual or groupings (classes) of cost centers and then applying one or more of the ratesetting characteristics specified

above. Most States have adopted some method of grouping whether by cost item, cost center or facility type to set limits (ceilings), on cost recognition or on reimbursement rates. The ceiling becomes the maximum level of cost recognition or reimbursement for such class and is generally set at some selected percentile (or other statistical measure) of arrayed costs. A class is therefore defined as a grouping of similar facilities or similar cost centers and is one of the primary criteria in determining the reasonableness of the reimbursement rate as covering the cost of an efficiently and economically operated provider.

B. Classification System (447.305). Where rates of payment or portions of rates or elements of cost are determined or judged against a class, the criteria on which the class is based must be reasonably related to the costs required to furnish services. The regulations require that if payment rates are determined for a class of facilities, the plan must set forth reasonable criteria for the class and the methods and standards for determining the rate of payment for the class. These criteria must also be addressed whenever providers or costs are grouped into classes, whether to establish rates or set ceilings on allowable costs:

- A State plan must provide that no class will be com-

posed of less than a reasonable number of facilities and that classes with less than a reasonable number of facilities will be equitably accommodated.

- Similar facilities must be compared.

- Facilities must be classified or compared along variables that are actually the basis of legitimate and necessary cost differences.

- State class justification must be based upon costs which are indicative of price-input resource distinctions and which are

rational, justifiable and material.

- Geographic price levels and level of care differences should be considered.

Implicit in any classification scheme is the idea that similar facilities should incur similar costs, and conversely, that facilities which are dissimilar will incur costs at different rates and degrees.

It is also necessary to verify that facilities are compared along variables that are actually the basis for legitimate cost differences. These "cost affecting variables" can be identified, and if all cost affecting variables can be accounted for or normalized, any remaining

difference will be due to relative efficiencies across the facilities. When classifying LTC facilities into definable groups whether for the purpose of developing uniform class rates, developing ceilings or screens in determining individual facility rates, or in grouping distinct cost centers together, it is, therefore, necessary to assure that similar facilities are being compared.

It should be noted that there is an inverse relationship between the degree of sophistication of the classification system and the level at which any ceilings, cost caps, rate levels, or other limiting provisions could be set. More simply stated, if a State were to develop the ultimately sophisticated classi-

fication and rate development system which recognized every factor affecting the production of nursing home services, such a plan could set its rates based on the actual experience of the lowest cost facilities in the group. A State has an obligation to purchase similar services at the lowest price possible consistent with quality care.

In class determinations, justification by the State must be formed on the basis of costs which are indicative of price-input resource distinctions and which are rational, justifiable, and material. Regardless of the type or number of variables utilized to determine classes, the State must be able to substantiate, by way of statistical and

financial data, the rationale for each.

As a minimum, class determinations should give consideration to geographic (e.g., SMSA, non-SMSA, urban/rural, etc.) and level-of-care (SNF, ICF, ICF/MR) differences. Geography and level of care may not become a required State class criteria but should nevertheless be reviewed and addressed by the State in choosing applicable class criteria. States are afforded broad latitude to use other classifiers such as bed size, type of facility, or other rationally supportable indicators. It will be difficult or impossible, however, to identify all cost affecting variables, and there will necessarily be some variation in any class that is developed that

will be due to other than relative inefficiency. Within the range of cost affecting variables, there is considerable discretion left to the State as to which variables to recognize as being cost affecting. This is a policy decision that should be left to the State. Review emphasis, though, is on the justification that is required of the State to substantiate the classification criteria chosen.

Generally speaking, the use of ownership (proprietary, non-proprietary, publicly-owned, etc.) as a grouping factor would not be acceptable because conditions of participation and services provided are defined in regulations and in no way are related to type of ownership or business organization.

To ascertain that the above criteria have been addressed, the State must provide justification for selection of the specific classification criteria. Examples of such justifications could include studies of provider cost variability (e.g., range of costs, skewness of distribution, frequency of distribution, mean-standard deviation, media-interquartile distribution, mode-frequency distribution, etc.).

Finally, it should be noted that it would be acceptable to recognize provider cost distinctions through various other reimbursement features as an alternative to a classification process. It is imperative, though, that such cost distinctions are recognized in the reimbursement process.

C. State Established Payment Ceilings. States may establish their own cost-related ceilings on reimbursement in addition to the Federally established ceilings (discussed under section VII, Upper Limits). The cost ceilings can be applied to individual cost centers, groupings of cost centers, or to aggregate per diem rates of facilities (or classes of facilities). Class criteria, as previously discussed, can also be utilized in conjunction with cost ceilings to consider valid costing differentials such as geographic price level variances.

The reimbursement ceiling(s) can be stated in an absolute monetary amount (e.g., $22.50 per patient day for ICF facility services) or it can be specified as some level of

statistical measure (i.e., a selected percentile of arrayed costs). If a fixed dollar per diem is specified, it must be indexed to recognize changes in economic conditions and trends. If such amount is not indexed, a plan amendment will become necessary to adjust the fixed per diem amount. In either case, the ceiling must represent a reasonable cost-related reimbursement level. Further, the review will focus on the several measurement bases upon which ceilings are generally tied. For example, States may associate their limits to weighted bed-days, Medicaid days, or number of providers. The review will look at the effects of these various measures and will require a reveiw of an equally weighted entry from each provider. Establishing a

cutoff point on the basis of some measure of central tendency requires that the measure be a good indicator of the items being measured; that is, the measure should be precise in a statistical sense.

The Federal plan review process, therefore, requires the justification of any limitations States choose to place on items or categories of cost; e.g., nursing, capital, administrative costs, or any other components or operating costs. Cost ceilings should generally be reviewed in conjunction with classification criteria to determine if an appropriate number of facilities are being (or will be) reimbursed their reasonable costs. Full allowable costs need not be reim-

bursed to all facilities under section 1902(a)(13)(E).

Thus, ceilings act to define and identify the maximum rate level of an efficient and economic provider. Such cost ceilings may be applied to both prospective and retrospective reimbursement systems. In order to be approvable, these ceilings must not result in excessive underpayments to providers whose costs are otherwise reasonable. Conversely, rates, particularly class rates, must not be set too high in order to avoid windfall profits to excessive numbers of providers.

D. Inflation Indexing. The methods and standards for determining payment rates must reasonably take into account economic conditions and

trends during the period for which the rates are set (42 CFR 447.303).

The State plan must describe the economic index used by providing the following specifications:

1. Identify the index used, its source, and its construction, including any weighting, seasonal, or time value adjustments.

2. Describe the method for establishing the base period from which the change in economic trend will be measured.

3. Describe the method for estimating the change in economic trend from the base period through the rate period.

4. Describe the method, if any, for adjusting the economic trend factor when estimates vary from actual experience by some stated percentage.

The State must also describe how the economic index will be applied to costs by providing the following specifications:

1. Identify the cost report period for which the data were obtained.

2. Identify the method used to adjust the cost data to a common base date.

3. Identify any deletions or additions to the data base and the rationale for the adjustments.

4. Specify whether audited or unaudited costs are being used. (Audited costs do not include costs as determined by preliminary, non-final desk audits). If any adjustment factor is applied to unaudited costs, explain its basis and source.

5. Provide that the economic index is not applied to fixed costs, e.g., depreciation and interest.

6. Provide for redetermining the economic trend at least annually.

This discussion will cover the factors which are used by the Department to judge whether an economic index is reasonable in its relevancy to industry costs and in its application for the development

of prospective reimbursement judgements.

Since the majority of current payment rates are based on past cost periods, an adjustment factor, or economic index, must be applied which will reflect the expected change in prices of goods and services which are used in the provision of long-term care services during the rate period.

Examples of economic indexes and sources of data used in State plans are relevant portions of the Consumer Price Index, the Implicit Deflator for GNP (Gross National Product), both compiled by the Bureau of Labor Statistics, U.S. Department of Labor; Personal Income and Wages in Non-Manufacturing,

Bureau of Economic Analysis, U.S. Department of Commerce. The State may be asked to justify the relevance of the particular index to the change in prices of goods and services which nursing homes experience in the production of their services in the particular State.

The review must also consider the economic index factor in relation to the other components of the State's reimbursement method. The economic index is only one factor in the overall plan. Its selection and application will not in itself assure that payment is reasonable, since other factors such as classes established, incentive provisions, and ceilings on selected costs will influence the total payment. However, the economic index's contribu-

tion to the reasonableness of the overall payment rate is important and thus it is a significant item for review.

HCFA's review will consist of examining for reasonableness the major elements of the process: the data used in its construction; the components of cost to which the index is applied; the weights applied; the base period; etc. The data elements specified in this section will be reviewed by HCFA in reaching its judgement concerning the reasonableness of a State's trend factors and application.

E. Occupancy Level. There is no regulatory requirement for use of an occupancy level limitation in computing payment rates for facilities

or classes of facilities. However, if a State chooses to use this factor to encourage efficient operations, it would be acceptable as part of the State plan. The State must provide in the plan the basis used to establish the occupancy level and be able to justify as reasonable, the occupancy level used and method of application. The occupancy level should be compared with the current statewide and area occupancy levels for reasonableness and appropriateness.

F. Rate Timing.

1. Interim rates in retrospective systems. Interim rates are determined to facilitate payment to a provider prior to a final rate determination in a retro-

spective system. The interim rate in a retrospective system should approximate as closely as possible the reimbursable cost the provider is currently incurring in furnishing covered services.

2. Final rates in retrospective systems. A final determination (i.e., the determination of the final payment amount) must be made timely by the State. Generally, a settlement in excess of 12 months from the receipt of a completed cost report would not be considered timely. Within this period, the State must inform the provider of the final rate, the adjustments made (i.e., disallowance of costs), and the rationale for

the adjustments. However, if a provider appeals the final rate, the "ultimate" final rate would not be established until the appeal process was complete.

3. Redetermination of payment rates. Payment rates for all types of systems must be redetermined at least annually and more frequently if the State so wishes. The process for such redeterminations must be fully articulated in the plan.

G. Ancillary Methods of Payment. The methodology for reimbursement of ancillary services must be fully explained in the State plan. The determination of payment to either the facility or other providers of

ancillary services rendered can effect the level of reimbursement.

Inasmuch as a wide variety of operational arrangements exists between States and providers concerning the furnishing of ancillary services, it is important to note the effects of these various arrangements on basic ratesetting. The primary areas of review relate to ensuring that cost comparisons of any kind are based on similar data. In order to accomplish this, it will be necessary to determine that the rate base adequately adjusts for the varying cost experience of those providers which (a) do not furnish ancillaries, (b) furnish all ancillaries, or (c) furnish some mix of ancillary services.

H. Profits and Incentives. The preamble to the regulations (Federal Register, July 1, 1976 and the supplemental statement issued in the Federal Register, February 6, 1978) governing the acceptability for determining reasonable reimbursement methodologies, have specified that a return on equity is the only element of profit that may be added-on as an item of allowable costs. (See Return on Equity under Allowable Costs, item III.C.) In addiion to the return on equity, other opportunities for profit are available in those States which elect a prospective reimbursement methodology or establish incentive payments based on a facility's costs as compared to a standard. Profit is available under such systems when (a) a facility's costs are below a prospec-

tively determined reimbursement rate; (b) when a facility's costs are below a class ceiling; (c) when a facility's costs are below a standard amount; or (d) when a facility's costs are below a uniform class rate. These other elements of profit allowable under the regulatory guidelines all result from the cost saving characteristics inherent in a prospective reimbursement system or from a system which provides specific performance incentives. The payment of profits under a prospective system operates as an incentive for efficient and economical operations as providers reduce their costs in order to qualify and maximize their return of the profit provision. The profit (incentive) provision must be reasonable cost-related.

The State plan must fully explain the incentive provision and the application of such by indicating (a) the incentive methodology, (b) the maximum reimbursement rates with incentives, and (c) minimum eligibility criteria for incentives.

I. Quality of Care Penalty (447.306). States have the option of establishing a ratesetting method that provides for a retroactive downward adjustment to a prospectively set lower rate for facilities with service deficiencies. For facilities which are classed by quality of service or level of care and the payment rates provide for adjustment to a prospectively set lower rate for service deficiencies, the plan must set forth the service deficiencies for which payment adjustments may be

made and the amount or percentage rate of the adjustments. A rate-setting method that provides for this type of downward adjustment is not subject to the upper limits of the overall Medicare limitation.

Quality of care penalties, in order to be approved, should meet the following criteria:

1. The plan must specify the deficiencies for which an adjustment to the rate may be made;

2. The plan should specify the methodology to be used in determining the amount of the rate adjustment for each deficiency;

3. The plan should provide for onsite verification, by the single State agency, when notified of the correction of a deficiency by the facility;

4. The downward rate adjustment should not be continued beyond the point at which the facility is able to show that the deficiency has been corrected.

J. The Appeals Process. The adoption of a formal administrative appeals provision into the State plan can help mitigate potential problems that are not accommodated for under the payment methodology. If a State incorporates an administrative appeals procedure into its long-term care reimbursement methodology, the

plan should contain the following information:

1. the designated appellate body;

2. appellate authority and responsibility;

3. the criteria under which an appeal can be filed;

4. rules of procedure;

5. scope and effect of a hearing decision.

VI. Payment Assurances (447.311)

The State must pay amounts determined for long-term care facility services according to the methods and standards set forth in the approved State plan.

This assurance must be stated in the plan.

In no circumstances may the payment rate vary depending on the availability of State resources; such a ratesetting method cannot be reconciled with the statutory requirement that the payment rate be on a reasonable cost-related basis.

VII. Upper Limits (447.315 and 447.316)

A. Federal Ceilings. There are specific Federally established rate ceilings (upper limits) and limitations that apply to State reimbursement systems. Under retrospective systems, title XVIII payment for long-term care services is applied as an overall ceiling test in one of two ways.

1. States may elect to provide for the application of the Medicare limitations on costs for skilled nursing facility routine services (Section 223 limits). The limits, when adopted, apply to reimbursement for routine nursing home costs but not to the costs of specialized care (i.e., ancillary services). These limits currently apply to Medicaid payment for SNF and ICF services made in those States that pay for such services under exactly the same method as Medicare. If a State uses the Medicare Principles of Reimbursement (HIM-15) without modification, the State reimbursement plan is then subject to the Schedule of Limits on Skilled Nursing Facility Inpatient

Routine Service Costs established and published as regulation for the Medicare program (under the authority of Section 1861(V)(1) of the Social Security Act).

2. Additionally, all States which pay a provider under retrospective payment systems may not pay more (statewide) that would have been paid under the Medicare principles of provider reimbursement. Payments meet this requirement (a) if, in a random sample of all medical facilities, the payment is not more than the amount that would have been paid under Medicare in at least 90 percent of the facilities in the sample or (b) if the average payment to all facili-

ties within a class is not more than the amount that would have been paid under Medicare.

To determine what would have been paid under Medicare (a) for facilities that participate in Medicare, the interim rate paid to the facility under Medicare (adjusted for services not included in the plan) may be used to determine the upper limit, and (b) for facilities that are not participating in Medicare, the State must set payment rates that are consistent with the intent that payments do not exceed amounts that would be determined using Medicare's principles. In complying with this requirement, the State need not use

Medicare's cost reports or methods of cost-finding.

B. Lower of Cost or Charges (LCC) (447.315). The regulations mandate that a State may not pay more for long-term care facility services than the provider's customary charges. Public facilities that provide services free or at a nominal charge are exempted from the lower of cost or charges requirement (447.315(b)).

Medicaid payments to a long-term care facility must be on a reasonable cost-related basis unless payment of the facility's charges for the services furnished Medicaid patients during a particular accounting year would result in payment of a lesser amount. Applica-

tion of the LCC principle to the Medicaid program assures that Medicaid payments to a health care facility do not exceed what the facility would have charged its Medicaid patients as private pay patients. The LCC principle, however, is not applicable to a public health care facility that imposes nominal charges. Medicaid payments to a public/nominal charge long-term care facility must be on a reasonable cost-related basis.

A public health care facility is defined as any health care facility operated by a Federal, State, county, city, or other local government agency or instrumentality. This definition includes facilities operated jointly by two or more government entities but does not

include facilities operated jointly by government and private organizations. A public facility's charges are considered nominal for an accounting year if the total charges for all the services the facility furnished during that accounting year are less than one-half the total reasonabe cost the facility incurred to furnish these services.

VIII. Public Notice

Federal regulation 42 CRF 447.205 requires that the State must give a 60-day public notice of proposed changes in methods and standards of reimbursement if the changes are expected to increase or decrease expenditures for a given service by 1 percent or more during the 12 months following the change.

This notice is not required if the change:

A. is made to conform to Medicare's methods or level of reimbursement, or

B. is required by court order.

The notice must:

A. describe the proposed change;

B. give an estimate of expected increase or decrease in annual aggregate expenditures;

C. explain why the reimbursement methodology or level of reimbursement is being changed;

D. identify where copies of the proposed change may be obtained;

E. given an address where written comments may be sent and reviewed by the public;

F. if public hearings are held, give location, date and time;

G. by published at least 60 days before the proposed effective date of the change;

H. appear as a public announcement in:

1. a State register similar to the Federal Register;

2. the newspaper of widest circulation in each city

with a population of 50,000 or more, or

3. the newspaper of widest circulation in the State, if there is no city with a population of 50,000 or more; and

4. be sent to HCFA regional office upon publication.

The State plans are required to incorporate the above provisions.

EXHIBIT A

TITLE XIX

Check List for State Plan Payment Methodology for Long-Term Care Services

State_____

Transmittal No._____

Effective Date_____

Date Reviewed_____By_____

OK	Not OK	
		I. Cost Reporting and Cost-Finding
__	__	1. 447.274(a). Cost reports due within 3 months after close of the cost reporting year.
		2. 447.274(b) & (c). The cost report must:

__ __ a. Include an itemized list of provider's total cost;

__ __ b. List all services provided;

__ __ c. Require costs to be based on generally accepted accounting principles, (unless modified by the regulations or HIM-15) and accrual method of accounting (except public institutions may use cash method).

The cost report should also include:

__ __ d. Certification.

__ __ e. Trial balance.

__ __ f. Cost-finding provisions.

__ __ g. Lower of cost or charges schedule.

__ __ h. Return on owner's net equity schedules, if applicable.

__ __ i. Other schedules to support plan methodology.

__ __ 3. 447.274(d). Cost report is uniform for all SNFs and ICFs. Report may be the same for both levels.

__ __ 4. 447.275(a). The plan specifies the inclusive dates of the cost reporting year, which need not be the same for all providers.

---

5. 447.276(a), (b), & (c). The plan must specify one cost-finding method for SNFs and one cost-finding method for ICFs; they may be the same. (ICFs/MR may also be different.)

__ __ a. Uniform cost-finding.

__ __ b. The method does not vary by type of ownership.

__ __ c. Medicare's 405.453(d) method utilized.

---

6. 447.277(a), (b), (c), & (d). The plan must reflect the following recordkeeping requirements:

__ __ a. Provider's financial and statistical records for cost report year kept at least 3 years.

__ __ b. Provider records available, on request, to the agency or HHS.

__ __ c. State agency keeps all cost reports at least 3 years after receipt.

---

7. 447.278. The plan must specify items of provider expense that are by definition allowable cost:

__ __ a. HIM-15 used.

__ __ b. HIM-15 with exceptions.

__ __ c. State defined cost definitions.

__ __ d. Reflect GAAP.

---

8. 447.279(a), (b), (c) & (d).
447.281(a), (b), & (c).
447.282
447.283. The plan adequately addresses the following issues and items:

__ __ a. Cost of certification standards, Federal and State, State licensing requirements, and other State requirements.

__ __ b. Comprehensive definition of routine services.

__ __ c. Comprehensive list of reimburseable services, including ancillaries and services not listed in 447.281.

__ __ d. Revenue offsets vs expense recoveries clearly defined.

__ __ e. Property payment clearly defined including basis and method of deprecia-

tion, lives of assets, recapture of gains on sales, capital cost, capital cost limitation, and handling of lease payments.

__ __ f. Specific and clear justification of:

i) Cost ceilings.
ii) Cost limitations.
iii) Inflation factors
iv) Occupancy factors (if applicable).

__ __ g. Specific and clear explanation of return on owner's equity, particularly if other than HIM-15 based.

__ __ h. Specify any requirements for extension of cost report time limits.

_____

_____

_____

__ __ 9. 447.282

447.283. The plan must specify criteria for identifying unallowable cost or non-cost items and specifically address:

a. bad debts.

b. charity and courtesy allowances.

__ __ 10. 447.284. The cost report must identify related organizations and costs.

II. Audit

__ __ 1. 447.290. Describe the State's procedures for audits.

__ __ 2. 447.291. Provide for desk review of all cost reports within 6 months to the State.

__ __ 3. 447.292(a). Provide for an on-site audit of all cost reports over a 3-year

period, beginning at the close of the first cost reporting year, and assure that no less than one-third of the providers are to be audited each year during this period. (See regulations for exemptions to this requirement.)

__ __ 4. 447.293(a). After the initial 3-year period, provide that onsite audits be performed each year of at least 15 percent of the participating facilities, at least 5 percent of which shall be selected on a random basis and at least 10 percent on the basis of exceptional profiles.

__ __ 5. 447.295(d). Provide that after each onsite audit a report of the audit shall be submitted to the State agency and that such reports shall be retained by the State agency for a period of not less than 3 years following the date of submission of the report.

__ __ 6. 447.296. Provide that overpayments found in audits will be accounted for on the HCFA-64 no later than the second quarter following the quarter in which overpayment was found.

III. Payment Determination

__ __ 1. 447.301. The plan must set forth the methods and standards used to set reasonable cost-related payment rates.

---

2. 447.302.

__ __ a. The methods and standards must reasonably take into account the allowable costs identified in the plan and used in the cost report.

__ __ b. The plan must reimburse in full the cost of an economically and effi-

ciently operated facility.

c. The methods and standards include the following in specific and justifiable terms:

— — i. Ratesetting characteristics fully explained.

— — ii. Classification and/or cost center groupings ascertainable.

— — iii. State established ceilings are reasonable, specific, and justified.

__ __ iv. Occupancy levels, when utilized, are specific and justified.

__ __ v. Methodology for interim rates (retrospective systems) fully explained and includes provisions for inflation adjustments.

__ __ vi. Final rates for retrospective system must be on a timely basis.

__ __ vii. Reimbursement for ancillary services fully explained.

iix. Incentives

— —

The plan is specific as to the basis for incentives to be paid, criteria for earning, method of payment, controls and/or ceilings, maximum and minimum rates and the relationship to efficiency, economy and quality of care.

---

3. 447.303. The plan specifies methods and standards that reasonably take into account economic conditions and trends during the time periods covered by payment rates (retrospective = interim: prospective = rate year).

__ __ a. Provides for an inflation indexing methodology.

__ __ b. Defines base period cost inflation proxies used, weighting factors, and adequately explains the application of such indexing methodologies.

__ __ 4. 447.304. Payment rates for all types of systems must be redetermined at least annually and more frequently is desired.

---

5. 447.305. Where rates of payment are determined on a class basis, the criteria on which the class and class rates of payment are determined shall be reasonable. The plan must include the following:

__ __ a. Clear indication of class.

__ __ b. Criteria for class is reasonable cost-related to the costs required to furnish services.

__ __ c. Specify that each class must contain a reasonable number of facilities.

__ __ d. Class should not be established based on ownership.

__ __ e. Consideration of level of care and geographic distinctions.

__ __ 6. 447.306. Where rates are determined prospectively with provision for retro-

active adjustment downward to a lower rate of payment for facilities with service deficiencies, the plan shall set forth the service deficiencies on the basis of which payment may be adjusted to the reduced rate.

IV. Payment Assurance

__ __ 447.311. Assure that the State will pay to a facility the amount determined for services furnished by the provider under the plan.

V. Upper Limits

__ __ 1. 447.315(a) & (b). In no case may the payment rate for services provided under the plan exceed the facility's customary charges to the general public for such services, except for those public facilities rendering such services free of charge or at a nominal charge.

__ __ 2. 447.316(a). Payments established retrospectively by the State agency may not exceed an upper limit determined in accordance with the principles of reimbursement for provider costs under Part A of Title XVIII of the

Act. Plan provides for random sample or class average as specified in this section.

VI. Public Notice

__ __ 447.205. Have the public notice requirements been met, if applicable?

EXHIBIT B

The "side-by-side" analysis of individual State long-term care plans is used to develop an understanding of the reimbursement methodologies being employed under Title XIX.

[State] REIMBURSEMENT PLAN FOR LONG TERM CARE SERVICES [TITLE XIX]

Provision	Current Plan	Proposed Plan
Transmittal Number		
Effective Date		
Type of Plan Material		
Method of Payment	Prospective/Retrospective. Supply a short synopsis of the payment rate determination, preferably highlighted by an easily read rate formula: (e.g.,R=C(T)+P+I) R = payment rate C = total allowable costs (except capital) T = trend (inflation) factor P = property costs (capital) I = incentive	
Base Year	Period in which base period costs are determined.	
Rate Year	Period in which rates are effective.	

Provision	Current Plan	Proposed Plan
Allowable Cost	Definition of allowable costs e.g., - based upon HIM-15 - based upon HIM-15 with the following exceptions - other, specify content	
Routine Service Costs and costs included in the rate composition	Specify items included in routine service costs (include: routine, ancillary, other costs that are allowable in computation of the payment rate).	
Level of Care	Specify SNF, ICF, ICF/MR or whatever (explain any unusual classification, e.g., Health Related Facility is defined as . . .)	
Classification System	Specify categories of class determination within each level of care such as by Region, Rating, Bed Size, SMSA, etc.	

Provision	Current Plan	Proposed Plan
Cost Finding	This section should explain the methodology of allocating direct and indirect costs into revenue producing centers.	
Apportionment	Specify the method of prorating that portion of allowable costs applicable to Title XIX.	
Cost Ceilings	Any ceilings on allowable costs should be detailed here. Applicable classes and/or cost center groupings and related ceilings should be specified. In addition, if ceilings are set by percentile or other statistical measurement, the method of determining the ceiling should be explained (i.e., percentile based	

Provision	Current Plan	Proposed Plan
	upon costs of facilities, bed size, utilization, etc.). This section should also specify whether the overall Medicare upper limit is applied and should explain how the limit is calculated.	
Occupancy Factor	Any occupancy factor and the application of such should be specified here.	
Inflation Factor	If the plan calls for the trending forward of base period costs in determining a prospective rate, it should be specified here. The application of the inflation index should be explained, the components of the index should be stated, the individual proxies should also be stated.	
Return on Equity	Specify whether the plan provides for a return on equity. If so, explain the determination and the	

Provision	Current Plan	Proposed Plan
	application of such.	
Incentives	Specify if incentives are allowed under the plan. Details should be specified regarding the criteria for eligibility, determination of the incentive amount, and any limits imposed on the incentive allowance.	
Capital Costs	A separate category should be provided here to explain the definition and the application of capital costs within the plan. Limitations on any capital cost component should be specified here. Adequate descriptions should include: a. basis for depreciation b. methods of depreciation c. estimated useful lives d. recapture provisions e. capital cost limitations	

Provision	Current Plan	Proposed Plan
Other	This category should be reserved to explain any unusual or particularly prominent features of the State plan. This section should also detail any variances in the State's implementation of the plan which are in opposition to the literal definition of the plan. Lastly, this section should contain any relevant plan provisions not specified above.	

Motion to Dismiss or Affirm

Office - Supreme Court, U.S.
FILED
OCT 13 1981
ALEXANDER L. STEVAS
CLERK

No. 81-537

IN THE

Supreme Court of the United States

October Term, 1981

BEECHWOOD SANITARIUM, a/k/a BEECHWOOD NURSING HOME,
Appellant,

v.

DAVID AXELROD, as Commissioner of Health of the State of New York; HOWARD F. MILLER, as Director of the Budget of the State of New York; and STATE HOSPITAL REVIEW AND PLANNING COUNCIL, a Council within the Department of Health of the State of New York,
Appellees.

ON APPEAL FROM THE APPELLATE DIVISION, FOURTH DEPARTMENT, OF THE SUPREME COURT OF THE STATE OF NEW YORK

MOTION TO DISMISS OR AFFIRM

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Question Presented

Do the provisions of the New York State Public Health Law, the Regulations promulgated by the Commissioner of Health of the State of New York pursuant thereto, and the administrative determinations made by that State official which established the Medicaid reimbursement rates payable to the appellant, as a proprietary nursing home, offend any rights guaranteed under the United States Constitution?*

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*The pertinent statutory and regulatory provisions are set forth in Appellant's Appendix to Jurisdictional Statement, at pages 22a through 91a.

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No. 81-537

IN THE

SUPREME COURT OF THE UNITED STATES

OCTOBER TERM, 1981

BEECHWOOD SANITARIUM, A/K/A BEECHWOOD NURSING HOME,

Appellant,

v.

DAVID AXELROD, as Commissioner of Health of the State of New York; HOWARD F. MILLER, as Director of the Budget of the State of New York; and STATE HOSPITAL REVIEW AND PLANNING COUNCIL, a Council within the Department of Health of the State of New York,

Appellees.

ON APPEAL FROM THE APPELLATE DIVISION, FOURTH DEPARTMENT, OF THE SUPREME COURT OF THE STATE OF NEW YORK

MOTION TO DISMISS OR AFFIRM

The appellees move the Court to dismiss the appeal on the ground that it is manifestly evident that this case presents no substantial Federal question. This appeal is

from an order of the Appellate Division, Fourth Department, of the Supreme Court of the State of New York, entered on January 16, 1981, which unanimously affirmed a judgment of the New York State Supreme Court, Monroe County, granting appellees' motion for summary judgment and denying appellant's motion for summary judgment. The Appellate Division on March 27, 1981 denied appellant's motion for reargument in that Court, or in the alternative, for leave to appeal to the Court of Appeals. On June 16, 1981, the Court of Appeals of the State of New York denied appellant's motion for leave to appeal. Reported at 79 AD2d 1084 and at 435 NYS2d 819. The order of the Appellate Division, Fourth Department, denying reargument or leave to appeal and the order of the Court of Appeals denying leave to appeal have not yet been reported.

The opinion of the Appellate Division, Fourth Department, is printed in appellant's Appendix to Jurisdictional Statement at 1a-5a. The orders denying reargument or leave to appeal are printed in appellant's Appendix to Jurisdictional Statement at 6a-8a.

Relief Requested

This Court should dismiss the appeal on the ground that it does not present a substantial Federal question. Alternatively, this Court should affirm for the reasons expressed by the Courts below.

Statutory Operation

The Medicaid Program under the Social Security Act makes available funds, to be supplemented by state contributions, to pay for the medical care of those whose means fall below certain financial standards. To obtain

Federal funding states are required to submit plans acceptable to the Social Security Administration. The statute (US code, tit 42) sets forth numerous requirements as to what constitutes an acceptable plan, but nowhere does the statute attempt to establish specific rates of reimbursement for those providing medical services. That duty is left to the participating states.

In New York State, the Legislature has charged the Commissioner of Health of the State of New York with the responsibility of setting the rates at which providers of medical services will be reimbursed (New York Public Health Law, Art 28). Pursuant to legislative authorization the Commissioner promulgated regulations setting forth formulae for establishing reimbursement rates and the methodology employed in carrying out the legislative mandate that the rates be reasonably related to the costs of the services rendered. The pertinent regulations are found at 10 NYCRR Parts 86 and 86-2.

Factual Statement

Appellant operates an eighty-bed proprietary nursing home in the City of Rochester, New York, providing medical services to patients including some whose medical expenses are paid through the Medicaid reimbursement plan. In order to obtain reimbursement, appellant filed with the Commissioner of Health financial reports, utilizing generally accepted accounting principles, and included as an element of cost, depreciation expense on its building and non-movable equipment.

The Commissioner of Health in certifying to the Director of the Budget of the State of New York the Medicaid reimbursement rates for the appellant for the years 1976 through 1979 excluded as a reimbursable item the depreciation expense attributable to appellant's building

and non-movable equipment and substituted therefor appellant's mortgage principal payments. Appellant sought administrative review of the rate determination and was advised that the exclusion of depreciation expense was a legal issue, not a proper subject for an administrative hearing, and that appellant's application constituted a challenge to the methodology relied upon by the Commissioner of Health.

Having failed to obtain relief at the administrative level, appellant commenced an action in the Supreme Court of the State of New York seeking, *inter alia,* a judgment declaring illegal the entire Medicaid reimbursement formulae for private proprietary nursing homes and declaring unconstitutional section 2808 of the Public Health Law and the regulations issued pursuant thereto.

After service of an answer on behalf of the appellees which contained various admissions, denials and separate and complete affirmative defenses, the appellant moved and appellees cross-moved for summary judgment. The Supreme Court in a bench decision granted summary judgment to appellees, dismissing the six causes of action set forth in the complaint.

Appellant appealed to the Appellate Division, Fourth Department, of the New York State Supreme Court. The Appellate Division unanimously affirmed the grant of summary judgment, noting that appellant's challenge was directed to the appellees' "calculation of rates" for its delivery of health care services to eligible recipients under the Medicaid Program and also to the accounting methodology employed in arriving at the applicable rates. The Appellate Court noted appellant's accounting argument and observed that "[W]hile it is true that providers of health care services are required to utilize generally accepted accounting principles in submitting financial

statistical report data to the State * * * no similar requirement is exacted from defendants by either State or Federal guidelines". The Court also noted that although Medicare regulations provide that depreciation is an allowable cost, in interpreting Medicaid guidelines it has been recognized that "the legislative history leaves no doubt that Congress intended states to have the option to adopt the Medicare principles and standards, but not to require that states adopt these principles and standards * * *"

Quoting from the decision of the United States Court of Appeals for the Fifth Circuit in *Alabama Nursing Home Association v. Harris* (617 F2d 388, 392), which recognized the state's flexibility in setting reimbursement rates, the Appellate Division noted that New York Public Health Law, §2807, subd 3, requires consideration, *inter alia,* of the elements of cost, and that the Commissioner in making reimbursement need only do so at a rate reasonably related to the costs of the services performed, not at a rate reflecting actual costs. The Court decided that so long as the formulae by which appellant is reimbursed have a rational basis and is reasonably related to cost, appellant has no cause for complaint, and that the statutes, regulations and the methodology utilized by appellees met the test of rationality. Finding that appellant failed to satisfy the heavy burden of showing that the formulae for reimbursement were arbitrary or capricious or invaded the constitutional prerogatives, the Court affirmed the *nisi prius* court's grant of summary judgment.

Thereafter, appellant sought leave to reargue before the Appellate Division, or in the alternative, leave to appeal to the Court of Appeals. Reargument and leave to appeal were denied. Next, appellant applied to the Court of Appeals for leave to appeal in that Court. Leave to appeal was denied. Appeal to this Court was then taken.

ARGUMENT.

The provisions of the New York State Public Health Law, the regulations promulgated by the Commissioner of Health of the State of New York pursuant thereto, and the administrative determinations made by that state official which established the Medicaid reimbursement rates payable to the appellant, as a proprietary nursing home, do not offend any rights guaranteed under the United States Constitution.

The central thrust of appellant's cause of action is that the determinations made herein and the regulations promulgated by the Commissioner fail to make it whole, fail to reimburse it for all its costs, are inconsistent with Federal statutory and regulatory provisions, discriminate against it on the basis of its form of ownership, fail to compute its reimbursement rate on an individual basis, and are based upon State statutes and regulations which are unconstitutional.

The "make it whole" argument was answered in *Matter of Broadacres Skilled Nursing Facility v. Ingraham,* 51 AD2d 243 (3d Dept, 1976), where the Court said (p 245):

> "It has heretofore been determined that the Commissioner need only reimburse nursing facilities at a rate reasonably related to the costs of services performed and need not reimburse for actual costs (Public Health Law, §2807; *Matter of Sigety v. Ingraham,* 29 NY2d 110)."

Appellant's challenge to the reimbursement rate on the ground that such rate does not reimburse it for all its costs, which, it claims, were efficiently incurred, was presented and rejected in *Matter of Presbyterian Hospital v. Ingraham,* 78 Misc 2d 152 (Sup Ct, New York County,

1974), mod on other grnds 49 AD2d 520 (1st Dept, 1975), affd 39 NY2d 867 (1976), where the *nisi prius* court said at page 155:

> "This argument overlooks the intent of subdivision 3 of section 2807 of the Public Health Law. That section does not require reimbursement for all efficiently incurred expenses; it requires that respondents make a projection, in advance, of a rate which shall be reasonably related to the costs of efficient production. It is then incumbent upon hospitals to attempt to keep their costs at or below that rate."

Furthermore, appellant's contention is certainly unwarranted in an industry where it is estimated that a minimum of 400 million dollars has been overcharged the Medicaid Program in the past 20 years (Stein, *Report on Nursing Homes and Health Related Facilities in New York State,* 1975 [p 7]).*

The Federal Medicaid statute, 42 USC §1396a(a) (13) (D), and regulation, 42 CFR §447.315(c), established not the minimum but the maximum rate of state reimbursement for Medicaid services rendered by facilities such as the appellant's (*Matter of Kaye v. Whalen,* 56 AD2d 111 [3d Dept, 1977], affd 44 NY2d 754 [1978], app dsmd 439 US 922 [1978]; *Matter of Sisters of Charity Hospital of Buffalo v. Whalen,* 64 AD2d 855 [4th Dept, 1978]; *Hempstead General Hospital v. Whalen,* 474 F Supp 398 [EDNY, 1979], affd 622 F2d 573 [2d Cir, 1980]).

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*A report by The Temporary State Commission on Living Costs and the Economy submitted to The Governor and The Legislature by Assemblyman Andrew Stein, Chairman.

In discussing the Federal statutory and regulatory framework in *Hempstead General Hospital, supra,* Judge Pratt, disposing of an inconsistency argument similar to appellant's, commented (pp 403, 404):

> "Under the Medicaid statute, the reasonable costs for reimbursement of in-patient hospital services are not to exceed the amount that would be determined under the federal Medicare provisions, 42 U.S.C. §1396a(a) (13) (D). Although there is no comparable statutory provision with regard to reimbursement rates for skilled nursing services, the same result is required by the federal regulations which similarly provide that such Medicaid reimbursement rates for such services shall not exceed Medicare limitations. See 42 C.F.R. §447.315(c).
>
> "More importantly for purposes of this case, in determining what methods and standards it will apply to ascertain reimbursement rates for both hospitals and nursing homes, the state may either adopt the federal Medicare standards, or adopt different methods and standards, provided they are approved by the regional Medicaid director. 42 CFR §§ 447.261(b) (2), (d) & 447.276(c). Thus, although the Medicare reimbursement methods and standards provide a maximum limit on reimbursement rates, they do not prevent a state from using other methods or standards in fixing its reimbursement rates."

Regarding implementation and prior approval of the State's amendments to its regulations by the Federal agency, appellees rely upon the decisions in *Matter of Kaye v. Whalen,* 56 AD2d 111, (3d Dept, 1977), affd 44 NY2d 754 (1978), app dsmd 439 US 922 (1978), which sustained the

same regulations challenged here, rejecting contentions identical to those of appellant. The courts sustained the regulations because the petitioners in *Kaye,* as the appellant in the case at bar, had not shown that the reimbursement rates violated the substantive standards established by the Federal statute.

Appellant also contends that the Commissioner's action discriminates against it because it is a proprietary facility. Appellant argues that a voluntary facility receives more advantageous treatment. Appellees submit that the distinctions based upon the form of ownership are permissible and valid under both the Due Process and Equal Protection Clauses.

In *Hempstead General Hospital v. Whalen,* 474 F Supp 398 (EDNY, 1979), affd 622 F2d 573 (2d Cir, 1980) a variation of the appellant's argument on Due Process was presented and rejected. In *Hempstead,* a voluntary not-for-profit operator wished to purchase the facilities of the plaintiff, consisting of a proprietary hospital, medical center and skilled nursing facility. The plaintiff in *Hempstead* contended that the voluntary operator's application to purchase its proprietary facilities must be approved because the State regulations conflicted with Federal Medicare regulations, and the limitation of the capital cost component in the reimbursement rate to "net depreciated value" rather than the purchase price resulted in confiscation of the plaintiff's property. The District Court, commenting upon a Supremacy Clause argument, said (p 409):

> "As part of their supremacy argument plaintiffs point to the federal regulations for Medicare which do permit reimbursement on the basis of purchase price provided the purchaser can demonstrate that the sale was bona fide and at a price not in excess of

> the fair market value. If the Medicare test were to be applied here, presumably the transfer to CCF would have been approved. However, the federal Medicare regulations do not control; they determine merely the maximum reimbursement rates. As indicated earlier, the state was granted the option of providing alternate standards, and it has done so by severely restricting the capital cost component of the reimbursement rate. Having done so with the approval of the Secretary, there is no conflict with federal statute or regulation and, therefore, no violation of the supremacy clause."

The District Court disposed of the confiscation argument in this language (pp 410, 411):

> "Guided by these standards, it is apparent that plaintiffs have not been deprived of their property without due process of law in violation of the fourteenth amendment. As before, plaintiffs have full right to use the medical center property. The challenged regulations impose no direct legal restraint upon the property or upon its use. There has been no physical entry by the state, no ouster of the owner, no legal interference with plaintiffs' physical use, possession or enjoyment of the medical center, nor any legal interference with the owner's power of disposition of the property."

The District Court continued (p 411):

> "But loss of a potential profit is not confiscation. Much governmental regulation restricts use and ultimately reduces value from what it would otherwise be in a 'free' market. A rezoning of property from one-half to two acre residential reduces

> its value, and deprives its owner of the opportunity to sell for the more concentrated residential use. But under well established precedents such a rezoning does not constitute confiscation unless it deprives the owner of any use of the property to which it is reasonably adapted."

The Court concluded with this observation (p 411):

> "The function of this court, however, is not to determine the wisdom of government health programs, of the state's regulations promulgated thereunder, or of the actions taken by the Public Health Council. What the public policy shall be in this area is left, for better or worse, to our legislators and administrators. This court's functions is to determine whether the state's regulations violate the Constitution of the United States, the federal statutes, or the federal regulations. After due deliberation, the court concludes that they do not."

It cannot be said that the reimbursement rate methodology applied herein violated appellant's right to due process. It is well established that a valid liberty or property interest is an essential prerequisite to the successful assertion of due process rights, and as we learn from *Board of Regents v. Roth,* 408 US 564, 577 (1972), property interests are "created and their dimensions are defined by existing rules or understandings that stem from an independent source such as state law." Under New York law, Medicaid providers such as appellant have "no property right in prospective reimbursement payments" (*Sigety v. Ingraham,* 29 NY2d 110, 115-116 [1971]).

That the state of the law, as it existed when appellant's reimbursement rate was fixed, imposed some inequality

between appellant and other providers delivering comparable services, does not warrant a conclusion that appellant's constitutional rights to equal protection have been infringed (see *Weinberger v. Salfi*, 422 US 749 [1975]; *San Antonio Ind. Sch. Dist. v. Rodriguez*, 411 US 1 [1973]; *Dandridge v. Williams*, 397 US 471 [1970]). The classifications drawn into question here must be sustained if they are rationally related to a legitimate governmental interest (*United States Dept. of Agriculture v. Moreno*, 413 US 528 [1973]). The interests protected by the Equal Protection Clause require only that the reimbursement methodology have some reasonable basis (*Massachusetts General Hospital v. Weiner*, 569 F2d 1156, 1160-1161 [1st Cir, 1978]). The interests protected by the Equal Protection Clause are not implicated solely and simply because the statutes or regulations do not act with mathematical nicety or because their impact results in some inequality between provider categories (*Massachusetts General, supra*, 569 F2d at 1160-1161); "[p]erfection in making the necessary classifications is neither possible nor necessary" (*Massachusetts Board of Retirement v. Murgia*, 427 US 307, 314 [1976]).

The predicate for appellant's Jurisdictional Statement in this Court is a *draft* of Standarized Review Criteria for Title XIX (Medicaid) Long Term Payment Plans prepared by the Health Care Financing Administration of the United States Department of Health and Human Services (HCFA).* The letter transmitting the plan to appellant's principal states that the draft "is not an official HCFA guide and is not intended as such." Such an unofficial statement clearly cannot satisfy jurisdictional requirements.

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*The criteria are set forth at page 92a of the Appendix to Appellant's Jurisdictional Statement.

Appellant's Jurisdictional Statement cites *Alabama Nursing Home Association v. Harris,* 617 F2d 388 (5th Cir, 1980), where the following revealing comments were made on congressional intent with respect to 42 USC §1396a(a) (13) (E) (p 392):

> "Congress intended that state authorities in developing methodologies for reasonable cost related reimbursement have great flexibility in the areas of cost-finding and rate-setting. The legislative history indicates that states are to be free to experiment with methods and standards for payment that would be simpler and less expensive than the complex Medicare reasonable cost formula. *See* S. Rep. No. 92-1230, 92d Cong., 2d Sess. 287 (1972) (hereinafter 'Senate Report'). *See also* 43 Fed. Reg. 4,861 at 4,862 (1978); 41 Fed. Reg. 27,300 at 27,300-02 (1976). Congress approved the setting of reasonable cost related rates on either a prospective or retrospective basis. *See* Senate Report at 288. *See also* 43 Fed. Reg. at 4,861-63. Congress similarly approved the setting of payment rates on a geographical, class, or facility-by-facility basis. *See* Senate Report at 287-88. *See also* 43 Fed. Reg. at 4,862-64; 41 Fed. Reg. at 27,304. Additionally, Congress intended that states have freedom both to define allowable cost items and to set a value on the reasonable cost of such of such items. *See* Senate Report at 287. *See also* Fed. Reg. at 27,303.
>
> "As a result of the flexibility that states possess in these areas, a state may select its reasonable cost related reimbursement rate from a spectrum of acceptable figures. As HEW has observed,

> a variety of cost-finding methods could be used to determine reasonable cost, which methods would produce a range of amounts representing reasonable cost. Rather then any one figure representing reasonable cost, each figure within the acceptable range represents a reasonable cost."

Any remaining doubt as to congressional intent should disappear, we submit, with consideration of 41 Federal Register No. 128 for Thursday, July 1, 1976; where at page 27303, the Department of Health, Education and Welfare responded to comments on its proposed regulations pertaining to reimbursement on a reasonable cost related basis for skilled nursing and intermediate care facility services.

The Federal Agency noted:

> "The Senate Report declares that States need not use the Medicare reasonable cost reimbursement formula, but that they should be free to develop simpler and less expensive methodologies.
>
> * * *
>
> "As pointed out above in the discussion of the Medicare ceiling, there is no single acceptable method for determining reasonable cost, but rather a variety of acceptable methods; it follows from this that there is no single figure that is the reasonable cost, but rather a spectrum of figures within an acceptable range, any one of which is a reasonable cost. The Department expects that a variety of acceptable methods for determining a reasonable-cost related payment rate will be developed."

In commenting upon various acceptable methods, the Department's response in the Federal Register cites with approval and describes in detail the New York "Fair-Rental" System, which appellant contends is inconsistent with Federal statutes and Regulations.

From all the foregoing, it is crystal clear, we submit, that there is no substantial Federal question presented by this appeal.

CONCLUSION.

The appeal should be dismissed, or in the alternative, the order affirmed.

Dated: Albany, New York
October 7, 1981

Respectfully submitted,

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